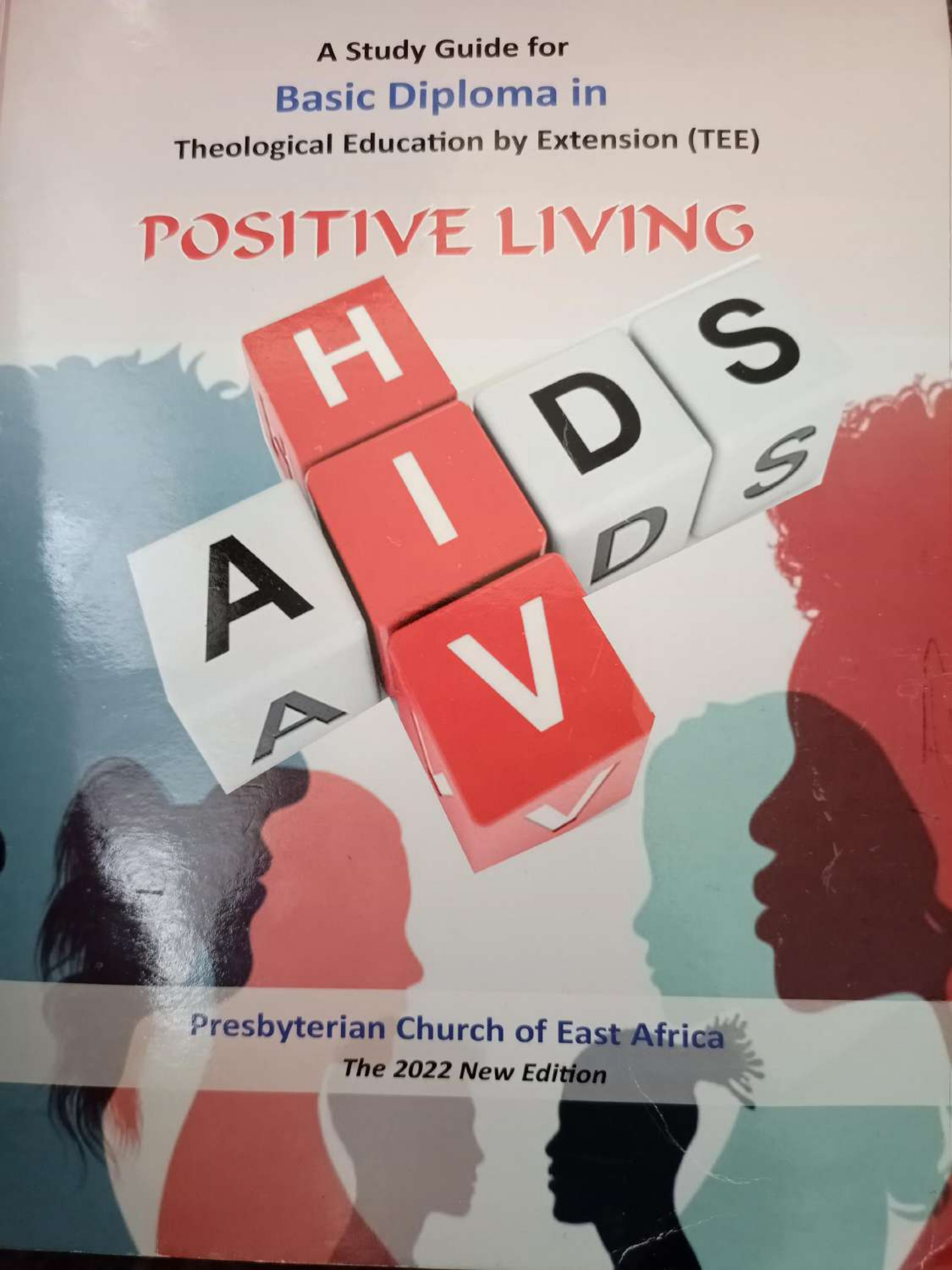
A Study Guide for

Basic Diploma in

Theological Education by Extension (TEE)

POSITIVE LIVING



Presbyterian Church of East Africa

The 2022 New Edition

POSITIVE LIVING

A Study Guide for Basic Diploma in Theological Education by Extension (TEE)

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This study guide is published by:
Theological Education by Extension Department
(Presbyterian Church of East Africa - PCEA)

Published 1986
Edited in 1993, 1995, 1996. 2008.
© PCEA 2021

Printed by:
Sycol **AGENCIES**, 0721206959,Nairobi.
sycolag@gmail.com

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Table of Contents

Table Of Contents v

List Of Acronyms And Abbreviations vi

Preface vii

Fore Word viii

Unit One : *Basic Facts About HIV And Aids* 1

Unit Two : *Overview Of HIV & Aids Statistics* 10

Unit Three : *Introduction To Human Sexuality* 18

Unit Four : *Human Sexuality, Adolescents And Young People's Sexual Reproductive Health And Rights (SRHR) In The Context Of The HIV Epidemic* 25

Unit Five : *Social-Economic Consequencies Of HIV & AIDS* 34

Unit Six : *Gender Bible And HIV* 41

Unit Seven: *HIV And Aids Prevention* 49

Unit Eight : *Gender Dynamics And HIV* 58

Unit Nine : *HIV And Faith Healing: Interacting With People Living With HIV , Emphasis On HIV Treatment And Adherence* 66

Unit Ten : *Introduction To Disaster And Risk Management For Religious Leaders* 76

Unit Eleven : *Health Promoting Churches And Preparedness* 85

List of Acronyms and Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ARASA	AIDS and Rights Alliance for Southern Africa
ARC	Action for the Rights of Children
ART	Antiretroviral Medicines
CAS	Chief Administrative Secretary
CD4	Cluster Differentiation 4
CSE	Comprehensive Sexuality Education
CSE	Comprehensive Sexuality Education
HIV	Human Immuno Deficiency Virus
KAIS	Kenya AIDS Indicator Survey
KENPHIA	Kenya population-based HIV Impact Assessment
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer & Inter sex
NASCOP	National AIDS and STI Control Programme
PEP	Post Exposure Prophylaxis
PrEP	Pre exposure prophylaxis
RDTs	Rapid Diagnostic Tests
SEA	Southern and East Africa
SOGI	Sexual Orientation and Gender Identity
SR	Sexual rights
SRH	Sexual and reproductive health
SRHR	Sexual reproductive health and rights
STIs	Sexually Transmitted Diseases
UNAIDS	The Joint United Nations programme on HIV & AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
W.H.O	World Health Organization

Preface

This book is a product of continued feedback from learners who kept raising the issue of relevance of the content in the earlier edition that was published in 1998. This is because information about HIV and AIDS keep evolving. The methods of response also keep changing as a result of the emerging knowledge.

The initial plan was to edit the earlier book but in attempting to do so, it emerged that most of the information and approaches were overtaken by time. It was necessary to initiate a new writing project altogether.

TEE department needed resources to do this project but being a time when the world was experiencing serious effects of the Covid pandemic, most of church resources were restrained. It was a big relief therefore when World Council of Churches - Ecumenical HIV & AIDS Initiatives and Advocacy (WCC-EHAIA) Eastern Africa Regional desk offered to help and put together a team of African scholars, who volunteer to build up the content of this book.

It is hoped that this book will a great resource to the TEE students in Kenya and beyond who seek to be equipped with right information and skills to enable them to employ the right approaches responding to the reality of HIV/AIDS.

Introduction

The Presbyterian Church of East Africa (PCEA) has been a pioneer church in responding to the HIV Pandemic. PCEA has sought to maintain a faithful witness in the face of the challenges posed by HIV & AIDS by offering suggestions about how local congregations can get involved, establishing a special desk on AIDS and involving the medical personnel who have attained the relevant expertise and experience.

The PCEA promotes the provision of factual information about HIV & AIDS and requires the members to protect persons living with HIV from stigma & discrimination. In addition, ministers are equipped with the necessary information on HIV and are encouraged to refer any difficult case they may encounter.

The PCEA acknowledges that poverty, gender inequality, human rights violations, stigma, prejudice, and unjust discrimination and marginalization are among the great impediments in dealing with this pandemic. In including the studies on the pandemic in the core curriculum of Theological Education by Extension (TEE), we seek, among other things, to equip learners to be able to respond effectively to HIV and AIDS. The PCEA has sought to help their membership examine the marginalizing social forces that foster the spread of HIV such as poverty, sexism, stigma, and discrimination through these studies.

We seek to explore how cultural and religious beliefs can contribute to the greater vulnerability of some groups and examine the forces at work towards unequal power relations. The PCEA has sought to become a HIV and AIDS competent church defined by the offering of compassionate pastoral care, development of church policies, allocation of resources, and advocacy by joining other interest groups working in the area of HIV.

The General Assembly has directed the HIV& AIDS and Drugs Control Desk to work with and for those affected by HIV and AIDS. In such efforts, the control desk have sought the partnerships of other caring organizations such as the World Council of Churches' Ecumenical HIV and AIDS Initiatives and Advocacy program and the National Christian Council of Kenya's HIV Department among others. The PCEA is challenged to learn from and partner with other churches, faith communities, governmental, and civil organizations to address the HIV and AIDS pandemic.

EHAIA Team.

UNIT ONE:
BASIC FACTS ABOUT HIV AND AIDS

Unit Description

This unit gives the basic knowledge about the HIV and AIDS pandemic; what it is, people's vulnerability to the infection, its transmission, managements, and the surrounding myths and misconceptions.

Unit Purpose

To equip the learner with basic knowledge and information about HIV and AIDS

Unit Objectives

At the end of the course the learner will be able to:

1. *Define what HIV and AIDS is*
2. *Provide relevant and factual information on the transmission, prevention and management of HIV and AIDS*
3. *Unpack the myths and misconceptions about HIV and AIDS*

DAY ONE: INTRODUCTION

What is HIV?

- HIV is an acronym for the Human Immuno deficiency Virus.
- HIV affects human beings
- It attacks the immune system; the very strength that the body would normally use to fight and get rid of the virus
- It is a virus (A virus is a disease causing sub-microscopic agent that only replicates inside a living cell)

A human body has a complex network of cells and proteins called the immune system whose function is to defend the body against infections. The immune system is made up of white blood cells which detect foreign materials when they enter the body such as viruses, bacteria, fungi, parasites etc. and produce antibodies that attack and destroy these foreign materials.

When the HIV enters the body, it attacks a specific type of the white blood cells called CD4 and does two things to it;

1. It destroys the cell, making it unable to detect foreign materials entering the body
2. It uses the cell's replication machinery to make several copies of the virus.

As the virus multiplies within the cell, the cell swells and eventually bursts, releasing more copies of the HIV into the body system. These copies of the virus attack other cells and the cycle

continues. This causes the number of white blood cells (the CD4 cells) in the body to continuously decrease to a level where they cannot fight off infections and diseases (a CD4 T-cell count of less than 200 per mm^3 of blood). At this stage, the immune system is considered to be deficient, and it is this medical condition caused by HIV which is referred to as AIDS.

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome.

- It is not inborn/not hereditary, thus the word "acquired"
- Immune Deficiency means reduced ability for the body to defend itself against infections
- Syndrome means a combination of associated symptoms)

AIDS is caused by HIV damaging the immune system cells until the immune system can no longer fight off other infections which it would normally be able to fight. It is a collection of opportunistic infections and symptoms that develop when an HIV infection is not well managed. They are opportunistic because they take advance of the bodies reduced ability to defend itself against them due to the destruction of CD4 cells by the HIV. A person with a deficient immune system is more vulnerable to a wide range of diseases including numerous cancers, Meningitis, tuberculosis among others, than a person with a good immune system.

Discussion Questions
HIV causes AIDS
What is the difference between HIV and AIDS?

DAY TWO: HIV TRANSMISSION

HIV transmission refers to the spread of the HIV from one person to another.
HIV transmission occurs when specific body fluids with an adequate amount of the virus enter into an HIV negative human body through:

- A mucus membrane such as the lining of the vagina, rectum or penis opening
- Shared injecting or sharp objects
- Broken skin (such as cuts and sores)
- Blood transfusion
- During childbirth and breast feeding

The body fluids in which the HI virus can exist with a concentration high enough to cause an infection include: -

- Blood
- Virginal fluids
- Semen

- Rectal fluids/anal mucous
- Breast milk

There are various ways a person can become infected with HIV, and these include:

- A HIV negative person having unprotected sexual intercourse with a person living with HIV who has a high viral load
- A HIV negative person having Transfusion of HIV positive blood
- A HIV negative person and a person living with HIV sharing needles and sharp objects (e.g., by injecting drug users, during circumcision or scarification)
- From a HIV positive mother to child if proper medical procedure and advice is not observed during pregnancy, birth and breastfeeding

Most HIV transmissions in sub-Saharan Africa occur through unprotected sexual intercourse. HIV cannot spread where there isn't any passage of the specific body fluids with an adequate amount of the virus into an HIV negative human body. Therefore, HIV does not spread through social activities like hugging, conversing, shaking hands, sharing edibles, and sharing utensils e.g. plates, etc. The virus does not spread through air and thus, no transmission can occur when a person living with HIV sneezes, coughs, laughs, or breathes nearby. It is not spread through urine and faecal material. It is, therefore, safe to share a toilet, bathroom, swimming pool, or hot tub with a person living with HIV.

Touching the skin of a person living with HIV bears no risk of transmission because the virus does not spread through sweat and tears. HIV does not spread through saliva. This is because saliva contains enzymes that break down the virus into non-infectious particles. However, if a person living with HIV has blood in their mouth, this blood contains the HIV virus that can ably cause a transmission if it passes into the body of another person who is HIV negative through open sores, bleeding gums and cuts). In other words, ordinarily saliva does not spread HIV. Insects and pets cannot transmit HIV; the virus cannot survive and replicate inside their bodies.

Vulnerability to HIV and AIDS

Every living human being is vulnerable to HIV and AIDS, as well as the unborn babies if their mother is living with HIV, they can contract the virus at birth.

To test your own vulnerability to HIV and AIDS, take a moment and answer the following questions:

1. Have you ever had sex?
2. Have you ever had an injection?
3. Are you married?
4. Have you ever had an operation / or an accident where blood was shed?
5. Have you ever had a blood transfusion?
6. Have you ever injected drugs?

7. Have you ever had a sexually transmitted infection?
8. Do you have children?
9. Have you ever travelled away from your sexual partner/spouse?
10. Are you human?

Grade yourself out of 100% if the answer to any of the questions is yes, you score ten marks and if it is no you score zero marks. Please note if an answer to any of the above questions is yes, then you are vulnerable to HIV infection irrespective of your gender, age, sexual orientation, religion, tribe, occupation, colour, social status, etc. However, it is worth noting that the higher the score, the more the vulnerability.

Discussion Question

a) Can HIV be transmitted through saliva? Give reasons for your answer.

b) Would you approve for two people to get married and have children if they are zero status different (i.e. One is living with HIV and the other is HIV-Negative)? Give reasons for your answer.

DAY THREE: HIV AND AIDS MANAGEMENT

HIV and AIDS is a manageable health condition and contracting the virus is not a death sentence. Management of HIV and AIDS involves three key aspects

1. Voluntary, Routine Counselling and HIV Testing
2. HIV and AIDS treatment adherence
3. Preventing the spread of HIV and AIDS

HIV testing

The only way one can know their HIV status is by doing an HIV test. One cannot know from someone's appearance whether they are living with HIV.

There are various types of HIV tests. These include the ELISA test, the invasive blood based, and the non-invasive saliva based Rapid Diagnostic Tests (RDTs). All the tests detect HIV anti bodies in a person's body. The ELISA is the most accurate test. The invasive RDTs detect antibodies in the blood (Invasive means they involve piercing the body so as to collect the blood sample). They include determine, Stat Pak and Unigold tests that are usually used as directed by the national HIV testing policy. The non-invasive RDTS detect for HIV antibodies in the saliva (Non-invasive because they utilise saliva and do not involve piercing into the body to collect a sample). They include the Oraquick test.

HIV Self-testing

Using the non-invasive oraquick test, one can test for their HIV status alone without any

assistance of the health worker. However, HIV self-testing with oraquick test is not a confirmatory test. So, if someone uses it and the result is positive, that person should go to the HIV health service centre for confirmatory tests and the relevant support.

After an HIV infection has taken place, there is a period within which the HIV antibodies or antigens in the body cannot be detected. This is called the window period and it usually ranges between 10 to 90 days depending on the type of test used and it also varies from individual to individual. However, HIV can still be passed on from one person to another during the window period. Knowing one's HIV status is the first step towards preventing new HIV infection. If one is HIV negative, they will take steps to remain negative and if one is HIV positive, they will take steps to prevent the spread of the virus to others and from re-infecting oneself. They will take measures to test for viral load and CD 4 count and seek medical advice in good time and start antiretroviral treatment early enough.

After one has been diagnosed as living with HIV, and they adhere to treatment both anti-retroviral treatment and treatment of other opportunistic infections, the person can lead a normal life, as their viral load can be undetectable. At this point it is difficult for one to transmit the virus through sexual intercourse. Discordant couples are advised to work towards achieving the undetectable level for the one who is positive before they can plan to have unprotected sex so as to conceive a baby. The person living with HIV must not relax at this point of undetectable viral load, because the virus is still in their blood but has been suppressed by the anti-retro viral medication, if they stop taking the medication the virus will once again replicate and destroy their immunity. If one does not take their medication consistently, they are likely to develop drug resistance and this would mean the same drugs they have been taking may no longer be effective in suppressing the virus, they may need to be put on the next line of treatment. Their health status may get complicated if they fail to adhere to the next line medication because if they get drug resistant to the next line medication it might be difficult to suppress the virus and they may die from opportunistic diseases. ***Therefore, treatment adherence is key in HIV management.***

Discussion question:
John, a committed Christian who has been praying to be healed of HIV goes for his regular health check-up and after undergoing some tests, the medical practitioner tells John that his viral load is undetectable. John shares this news with his pastor who invites him to bring thank you offering to church and after praying for John, the pastor tells him that he has been cured of HIV. Should John believe that he has been cured and stop taking the ARVs or should he continue taking the ARVS? Give reasons for your answer.

DAY FOUR: HIV AND AIDS PREVENTION

All the ways through which HIV is transmitted are known and with this knowledge, we can prevent the transmission of the virus.

The sexual transmission of HIV can be prevented through, abstaining from sex, having only one mutually faithful sexual partner where both partners are HIV negative and through the correct use of condoms. In discordant partners PrEP (Pre exposure Prophylaxis) the taking of a prescription drug as a means of preventing HIV infection in an HIV-negative person): the use of antiretroviral drugs for PrEP can offer some protection against HIV infection. Similarly, in cases where one has been exposed by having unprotected sexual affair especially in cases of Rape or forced sex, PEP (Post Exposure Prophylaxis), the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure. Safe male circumcision also reduces the risk of HIV transmission but it is only fully prevented if used together with the other HIV prevention methods.

The non-sexual transmission of HIV can be prevented through ways indicated in the table below.

Means of HIV transmission	Means of Prevention
Mother to child transmission	A pregnant woman should test for HIV and if found to be living with the virus, She should enrol and adhere to the recommended treatment combined with ART She should receive antenatal care from a health centre with HIV services for pregnant women and should give birth from the hospital under the care of a trained medical professional. The mother should follow the medical professionals' advice about breastfeeding.
Blood transfusion	Screen blood for HIV before transfusion and ensure that only safe blood components are transfused
Sharing sharp objects	Avoid sharing sharp objectives and in cases where it's inevitablelike in the salon and the ba rber shop, sterilize the objects immediately after using them with each particular individual. Don't use a shared sharp object without sterilizing it.
Broken skin	Avoid any contacts that can put you at risk of contracting or spreading HIV until when the broken part of the skin is fully healed.

At the moment, there is no cure for HIV; neither do we have a vaccine for the same, much as research is underway for a cure and a vaccine. However, HIV and AIDS can be treated with antiretroviral medicines. Anti-retroviral drugs work by inactivating the HIV replication machinery, making it unable to destroy the body's immune system. If used properly, the antiretroviral medicine can suppress the amount of HIV in one's body (viral load) to below detectable levels and that moment, the person is said to be having an undetectable viral load. The lower the viral load, the less one's capacity to passing on the HIV virus to other people and the less the possibility to develop AIDS is. Actually, research has shown that people with an undetectable viral load cannot pass on the virus.

Antiretroviral drugs enable many people living with HIV to live long and healthy lives. However, if one fails to adhere to the ART, one could develop drug resistance and eventually succumb to AIDS. Starting antiretroviral treatment requires commitment – medication has to be taken every day, and for the rest of a person's life.

Many people have failed in drug adherence because their pastor or a certain prophet has claimed to pray for them and be healed of their HIV status. This is unfortunate and needs to be addressed as a matter of urgency.

BE WARNED! So far HIV has no cure; do not be deceived. However, God has performed many miracles to provide us with wisdom, knowledge, and tools to handle and overcome the virus and we know that it is possible to have an HIV free generation.

Discussion Questions

Identify the ways through which we can eliminate the spread of HIV and AIDS?

DAY FIVE: HIV FACTS RE: SEX AND MARRIAGE

HIV and AIDS has very significant implications for peoples' sexual and marriage life. There exist numerous questions about sex, marriage, and HIV. Here are some of the very important facts about HIV in relation to sex and marriage.

People living with HIV enjoy and do have sex just like everyone else. However, if one involves in unprotected sexual intercourse with a person living with HIV with a detectable viral load, there is a great risk of transmitting the virus.

Different people have different strains of the virus. If one person living with HIV engages in unprotected sex with another person with a different HIV strain, there can be a re-infection where one is infected with a different strain of the virus in addition to the strain already existing in their body. HIV reinfection has various negative consequences and can cause drug

resistance. To avoid reinfection, people living with HIV should consistently and correctly use condoms when engaging in sexual intercourse.

A person living with HIV can have sex with a person who is HIV negative without passing on the virus to them. Although not every sexual encounter with an HIV positive person result in infection, it is advisable that to ensure maximum prevention of transmission the person living with HIV has an undetectable viral load and is adhering to their ART or the two are correctly and consistently using condoms. A combination of both is the best way of assuring HIV prevention. Given the fact above, a person living with HIV and a person without HIV can marry and stay together safely, healthy and without infecting one another with the HIV virus. Such people in a sexual relationship but with a differing HIV status are called sero-discordant partners or couple.

Sero-discordant partners and partners who are both living with HIV can give birth to children who are HIV negative. All they have to do is to follow medical advice on when and how to conceive, how to take care of the pregnancy, what to do at child delivery and after child delivery.

Myths and misconceptions about HIV and AIDS

Myths are false ideas that are at times widely held and misconceptions are wrong and inaccurate ideas that are common about something, HIV and AIDS in this case. Several myths and misconceptions about HIV and AIDS exist among people in various communities. Some of the common ones include the following

1. One can get HIV and AIDS by being around people living with HIV
2. Mosquitos spread HIV
3. People living with HIV cannot have HIV negative children
4. If you marry a person living with HIV, you will definitely contract the virus
5. If one takes PrEP, they don't need to use condoms
6. Two people living with HIV are free to have unprotected sex; after all they are both living with the virus
7. You can tell if someone has HIV by looking at them
8. If one is HIV positive, it means that they would die soon
9. A person living with HIV cannot be as productive as a person who is HIV negative
10. Using condoms is a sinful practice.
11. HIV is a punishment for promiscuous behaviour
12. People who succumb to HIV and AIDS related complications cannot go to heaven

The list of myths and misconceptions can fill the volume of this module. Feel free to add to the

list by identifying other common myths and misconceptions in your community and most importantly understanding how to respond to each appropriately.

These myths and misconceptions are usually rooted in the lack of accurate knowledge and information about HIV and AIDS, inaccurate communication concerning HIV and AIDS issues and prejudice

Discussion Questions

a) *What do you understand by the term discordant couple?*
b) *List some of the myths and misconceptions about HIV and AIDS in your community and how to counteract them.*

UNIT TWO:
OVERVIEW OF HIV & AIDS STATISTICS

Unit Description

This course analyses the availability, analysis, role and use of HIV &AIDS statistics. The course considers the sources of HIV & AIDS statistics and the use of these statistics by various stakeholders. The course makes use of some pivotal aspects of the statistics to uncover the context of HIV & AIDS in the global south. The course shall include reflections of the available statistics.

Unit Purpose

The purpose of this course is to introduce the students to an Overview of HIV & AIDS Statistics. The course is aimed at helping individual learners appreciate the importance HIV & AIDS Statistics and their use within the context of religious communities. The course seeks to shape the learners' view on the extent and prevalence of HIV & AIDS around the world and closer home, in the global South.

Unit Objectives

At the end of the course, you will be able to:

1. Consider the sources of HIV &AIDS statistics.
2. Describe the availability of HIV & AIDS statistics
3. Articulate some roles and uses of HIV & AIDS statistics.
4. Underscore the emerging trends emerging from HIV & AIDS statistics globally.
5. Understand and reflect upon some of the available statistics.

Unit Outline

- Day One: Sources of HIV &AIDS statistics
- Day Two: Availability of HIV & AIDS statistics
- Day Three: Some roles and uses of HIV & AIDS statistics
- Day Four: Emerging trends from HIV & AIDS statistics globally
- Day Five: Reflection upon some of the available statistics

DAY ONE: SOURCES OF HIV & AIDS STATISTICS

There are various sources of HIV &AIDS Statistics. It is important to only refer to credible sources as this is a cornerstone of any continued engagement with the material availed. When there is mistrust of official HIV & AIDS information amongst segments of the population, any interventions and advocacy measures are curtailed (Guttmann 1998:466). Some sources that can be used for HIV &AIDS statistics include UNAIDS, WHO, USAID, NASCOP etc. See the references for additional sources.

Herein, I list two: UNAIDS- https://www.unaids.org/en/resources/fact-sheet
THE World Health Organisation-https://www.who.int/news-room/fact-sheets/detail/hiv-aids.

For this section and during this lesson we shall make a sharp focus on UNAIDS summary statistics as indicated below.

GLOBAL HIV STATISTICS

(https://www.unaids.org/en/resources/fact-sheet; **for an updated schedule)**

- 26 million [25.1 million–26.2 million] people were accessing antiretroviral therapy as of the end of June 2020.
- 38.0 million [31.6 million–44.5 million] people globally were living with HIV in 2019.
- 1.7 million [1.2 million–2.2 million] people became newly infected with HIV in 2019.
- 690 000 [500 000–970 000] people died from AIDS-related illnesses in 2019.
- 75.7 million [55.9 million–100 million] people have become infected with HIV since the start of the epidemic (end 2019).
- 32.7 million [24.8 million–42.2 million] people have died from AIDS-related illnesses since the start of the epidemic (end 2019).

People living with HIV

- In 2019, there were 38.0 million [31.6 million–44.5 million] people living with HIV.
    - 36.2 million [30.2 million–42.5 million] adults.
    - 1.8 million [1.3 million–2.2 million] children (0–14 years).
- 81% [68–95%] of all people living with HIV knew their HIV status.
- About 7.1 million people did not know that they were living with HIV.

People living with HIV accessing antiretroviral therapy

- As of the end of June 2020, 26.0 million [25.1 million–26.2 million] people were accessing antiretroviral therapy.
- In 2019, 25.4 million [24.5 million–25.6 million] people were accessing antiretroviral therapy, up from 6.4 million [5.9 million–6.4 million] in 2009.
- In 2019, 67% [54–79%] of all people living with HIV were accessing treatment.
    - 68% [54–80%] of adults aged 15 years and older living with HIV had access to treatment, as did 53% [36–64%] of children aged 0–14 years.
    - 73% [60-86%] of female adults aged 15 years and older had access to treatment; however, just 61% [48-74%] of male adults aged 15 years and older had access.
- 85% [63–100%] of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their child in 2019.

New HIV infections

- New HIV infections have been reduced by 40% since the peak in 1998. - In 2019, around 1.7 million [1.2 million–2.2 million] people were newly infected with HIV, compared to 2.8 million [2.0 million–3.7 million] people in 1998.
- Since 2010, new HIV infections have declined by 23%, from 2.1 million [1.6 million–2.9 million] to 1.7 million [1.2 million–2.2 million] in 2019. - Since 2010, new HIV infections among children have declined by 52%, from 310 000 [200 000–500 000] in 2010 to 150 000 [94 000–240 000] in 2019.

AIDS-related deaths

- AIDS-related deaths have been reduced by 60% since the peak in 2004. - In 2019, around 690 000 [500 000–970 000] people died from AIDS-related illnesses worldwide, compared to 1.7 million [1.2 million–2.4 million] people in 2004 and 1.1 million [830 000 –1.6 million] people in 2010.
- AIDS-related mortality has declined by 39% since 2010.

For more details, refer to the **UNAIDS FACT SHEET**

Discussion Question
What is the importance of Global HIV & AIDS statistics?

Its crucial for understanding the pandemics scale, tracking progress towards ending it and informing effective prevention and treatment strategies

Day Two: Availability of HIV & AIDS statistics

Yesterday we learnt on the sources of HIV &AIDS statistics, today we want to learn about the availability of HIV & AIDS statistics by region. Although there are global statistics that are generally found in the listed sources given earlier, we further consider the availability of these statistics in context. Within the Kenyan context, it is important to focus on how available within the country are relevant statistics and how the given statistics are segregated within regions. The Kenya Population-based HIV Impact Assessment (KENPHIA) was carried out, to include a cross-sectional household survey undertaken to describe the HIV epidemic in Kenya. KENPHIA had three primary objectives:

I. To estimate the National incidence of human immunodeficiency virus (HIV) infection
ii. To determine the National prevalence of viral load (VL) suppression (VLS) among persons living with HIV
iii. To assess the prevalence of HIV, nationally and by County

In general, this survey concluded that Kenya has over the years been counted as having the fifth-largest number of persons living with HIV in the world, and HIV continues to be a leading cause of adult morbidity and mortality (UNAIDS 2018). Kenya has carried out several surveys

such as the Demographic and Health Survey with HIV testing in 2003. In 2007, a Kenya AIDS Indicator Survey (KAIS) was carried out. The follow-up 2012 KAIS estimated the National HIV prevalence among adults (defined as those aged 15-64 years) to be 5.6%, which was a significant decline from KAIS 2007, which found a prevalence of 7.1% (Kenya AIDS indicator survey 2012).

According to UNAIDS, the Kenyan context provides the following estimates:

HIV and AIDS Estimates

✓ Adults and children living with HIV	1 500 000
✓ Adults aged 15 and over living with HIV	1 400 000
✓ Women aged 15 and over living with HIV	880 000
✓ Men aged 15 and over living with HIV	510 000
✓ Children aged 0 to 14 living with HIV	110 000
✓ Adult aged 15 to 49 HIV prevalence rate	4.5%
✓ Women aged 15 to 49 HIV prevalence rate	5.8%
✓ Men aged 15 to 49 HIV prevalence rate	3.2%
✓ HIV prevalence among young women	2.4%
✓ HIV prevalence among young men	1.3%
✓ Adults and children newly infected with HIV	42 000
✓ Adults aged 15 and over newly infected with HIV	35 000
✓ Women aged 15 and over newly infected with HIV	22 000
✓ Men aged 15 and over newly infected with HIV	13 000
✓ Children aged 0 to 14 newly infected with HIV	6800
✓ HIV incidence per 1000 population (adults 15-49)	1.47
✓ HIV incidence per 1000 population (all ages)	0.92
✓ Adult and child deaths due to AIDS	21 000
✓ Deaths due to AIDS among adults aged 15 and over	17 000
✓ Deaths due to AIDS among women aged 15 and over	7300
✓ Deaths due to AIDS among men aged 15 and over	9400
✓ Deaths due to AIDS among children aged 0 to 14	4300
✓ Orphans due to AIDS aged 0 to 17	660 000

Further reference can be made to the **Kenya AIDS Indicator Survey (KAIS) 2012 Adult DATA SHEET and the Kenya Ministry of Health Kenya Aids Response Progress Report 2018.**

Discussion Question
What is the HIV & AIDS estimates among young people and what do these imply?

Day Three: Some Roles and Uses of HIV & AIDS Statistics

Yesterday we handled availability of HIV &AIDS statistics with reference to context. Today we want to go ahead and examine some roles and uses of HIV &AIDS Statistics. The segregated statistics clearly help to understand various aspects of the populations.

National surveys and their attendant statistics continue to provide important insights into progress toward HIV epidemic control. They add to the knowledge associated with National or Global Prevalence of HIV-related risk behaviour, knowledge, and attitudes. At the same time, statistics allow for an overview of behavioural and demographic determinants of HIV incidence and prevalence in different regions.

The statistics provided across age are useful to deduce whether HIV prevalence increased with advancing age, whether it peaked at some age group and the variations between women and men.

All available statistics lead to the following:

- ✓ Groups of people with highest risk factors include men who have sex with men (MSM), injecting drug users (IDUs), and sex workers (SW).
- ✓ Prevalence is high in low- and middle-income countries
- ✓ There is a positive relationship between lower socioeconomic status and HIV progression
- ✓ Indicates the access to prevention, care, and treatment
- ✓ Gender inequalities, differential access to services, and sexual violence and how it increases women's vulnerability to HIV
- ✓ HIV primarily affects those in their most productive years and that about half of new infections are among persons below the age 25 years

This information informs the policy makers of the best options to combating the disease and its routes of infection.

Statistics are further used to locate

- ✓ Differences between cultures and countries in terms of contraceptive use, educational attainment, circumcision practices and access to treatment for sexually transmitted diseases (STDs). These differences can therefore explain much of the observed variation in HIV prevalence levels
- ✓ Intervention measures
- ✓ To enable the Ministry of Health of a country plan the roll out of antiretroviral therapy
- ✓ To inform educational forums

- ✓ To aid prevention planning groups, policy leaders, health care providers, and people living with HIV to highlight disparities in care and services
- ✓ To advocate for needed resources.

Discussion Question
How useful is the knowledge of HIV & AIDS statistics in your country?

Its used for guiding public health strategies eg doing budget for the medical sector
- Create campaigns on reducing stigma and promoting prevention efforts by offering free seminars, testing and counseling.

Day Four: Emerging Trends from HIV & AIDS Statistics Globally

Having considered the role and use of HIV & AIDS statistics yesterday, today we want to focus on the emerging trends from HIV & AIDS statistics globally. In order to capture the statistics in an agile way, reference has been largely made to ***HIV prevalence,*** which is defined as the number of people with HIV at a given time regardless of the time of infection, whether the person has received a diagnosis (aware of infection), or the stage of HIV disease. Global and national statistics are incorporated in HIV surveillance reports, which are useful to disseminate data about HIV and AIDS for example, the number and population rates of HIV diagnoses, the number of people with HIV, and the number of people receiving HIV medical care.

Globally, new HIV infections have been falling in recent years. This is a welcome result following the ravages faced by many due to the pandemic in years past. However, there are some areas where the HIV infection rates have consistently risen at alarming rates. Globally, health organizations have described the Philippines as having one of the fastest growing HIV epidemics in the world. It has been shown that over the years, from 2010 to 2015, more than 20,000 new HIV infections were recorded. That's more than 4 times as many as had been recorded since HIV was first reported in the Philippines in 1984. It is important that each country understands the factors that are behind the climbing HIV infection rates and what needs to be done to stop the spread of new infections.
According to https://www.avert.org/global-hiv-and-aids-statistics,

There is renewed concern that the annual number of new infections among adults has remained static in recent years. In 2018, there were roughly 1.7 million new HIV infections – an insignificant improvement on 2017 (1.8 million).

In the past eight years, global new HIV infections have declined by just 16%, from 2.1million in 2010. Although this is nearly half the number of new infections compared to the peak in 1997 (2.9 million), the decline is not quick enough to reach the target of fewer than 500,000 by 2020....

The reduction in new HIV infections has been strongest in the region most affected by HIV, East and Southern Africa, where new HIV infections have been reduced by 28% since 2010. However, in 2017 new HIV infections rose in around 50 countries. In Eastern Europe and Central Asia, the annual number of new HIV infections has doubled, and new HIV infections have increased by more than a quarter in the Middle East and North Africa over the past 20 years.

Discussion Question
The gains that had been made in HIV &AIDS prevention globally have been wiped away! Discuss the validity of this statement.

Day Five: Reflection upon some of the available statistics

Having looked at the HIV & AIDS statistics made available through various outlets, both globally and locally, what is our take from all this? How do these statistics enact, and challenge us? Are these mere figures or do they in any way speak to our inner being to engage and be part of the solution?

Should we in the church reflect further on these statistics in order to be pace setters in our congregations? How are we to use these statistics as leaders in our churches? Should we just note these and forget about them? How does our theologising change in view of the same?

Let us consider even more closely the preliminary findings of the Kenya Population-based HIV Impact Assessment (KENPHIA) 2018 survey report from the Ministry of Health, Kenya dated 20th February 2020. The report indicates that:

- ✓ Kenya's HIV prevalence now stands at 4.9%.
- ✓ The prevalence of HIV in women is at 6.6%, while that in men is at 3.1%.
- ✓ The gender disparity in the burden of HIV is even greater than 3 times in between the ages of 20-34 years.

This data shows the ever-widening gap from the 2007 & 2012 KAIS surveys that are now showing a significantly higher burden of the disease in women compared to men. The same worrying trend is also emerging in the sub-Saharan region as evidenced by other regional PHIA surveys, Dr. Rashid noted.

The KENPHIA report, county HIV prevalence statistics indicated that in Kenya, the top five HIV high-prevalence counties with a prevalence of more than 9% were Homa Bay, Kisumu,

Siaya, Migori and Busia; while prevalence was lowest in nine counties of Samburu, Tana River, Garissa, Wajir, Mandera, Marsabit, Kiambu, West Pokot, and Baringo.

Key findings from this report provided statistics which included the national HIV incidence, HIV prevalence and viral load suppression in people living with HIV.

Discussion Question

Imagine you are a posted as a church minister in one of the high prevalence counties. Will these statistics in any way inform your sermons? Will these statistics in any way inform your engagement with youth?

Yes. to help create an enlightment on the awareness and spread of the v

UNIT THREE:
INTRODUCTION TO HUMAN SEXUALITY

Unit Description

This course examines the meaning and importance of human sexuality in the lives of believers. The course seeks to dispel myths and misunderstandings of human sexuality. The course makes use of some pivotal biblical texts to explain human sexuality. The course will relate human sexuality to the mission of the church.

Unit Purpose

The purpose of this course is to introduce the students to the study of human sexuality. The course is aimed at helping individual learners appreciate the importance of human sexuality throughout the life of believers. The course should shape the learners' witness healthy, enduring and positive relationships with all people of God.

Unit Objectives

At the end of the course, you should be able to:

1. Define human sexuality.
2. Describe human sexuality as expressed in the creation narrative.
3. Articulate the centrality of companionship in human sexuality.
4. Articulate the status of procreation in human sexuality.
5. Understand the skills needed for healthy and positive human relationships.

Unit Outline

- Day One: Definition of Human Sexuality
- Day Two: Creation and Human Sexuality (Genesis 1: 26-28)
- Day Three: Companionship and Human Sexuality (Genesis 2:18)
- Day Four: Procreation and Human Sexuality (Genesis 1:28a)
- Day Five: Life Skills and Human Sexuality
- References

Day One: Definition of Human Sexuality

'Sexuality' [refers to] a core dimension of being humans which includes: the understanding of, and relationship to, the human body; emotional attachment and love; sex; gender; gender identity; sexual orientation; sexual intimacy; pleasure and reproduction. Sexuality is complex and includes biological, social, psychological, spiritual, religious, political, legal, historic, ethical, and cultural dimensions that evolve over a lifespan (UNESCO Education Sector, 2018). Since sexuality brings together sex and gender, it is important to briefly define sex and gender

here. **Sex** refers to a set of biological characteristics that mark human beings as male, female, or intersex. These biological characteristics are both external and internal, visible, and invisible. **Gender** refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. We normally think of only men and women when we think of gender, however, gender is best expressed in terms of masculinity, femininity, and transgender.

- ✓ Sexuality refers to the individual and social meanings of interpersonal and sexual relationships, in addition to biological aspects. Sex is biological, gender is social, and sexuality is a combination of sex and gender.
- ✓ Sexuality is a biological and social construct, most easily understood within the variability of beliefs, practices, behaviours and identities. Being male, female or intersex is a biological fact. At birth, every individual is assigned to one of these categories. Biological features are therefore the basis for the differences that exist among these three categories (Gunda, 2017). How males, females or intersex behave and understand themselves depends on what society teaches them.
- ✓ "Gender refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women. These differences constructed between men and women become the basis upon which individuals are categorized by their respective societies"(Gunda, 2011).
- ✓ The expectations that govern sexual behaviour differ widely across and within cultures. Certain behaviours are seen as acceptable and desirable, while others are considered unacceptable. This does not mean that these behaviours do not occur, or that they should be excluded from discussion within the context of sexuality education.
- ✓ Sexuality is present throughout life, manifesting in different ways and interacting with physical, emotional, and cognitive maturation.
- ✓ Education is a major tool for promoting sexual well-being and preparing children and young people for healthy and responsible relationships at the different stages of their lives.
- ✓ Human sexuality is best understood through the circles of relationships that continue to grow as we grow older, beginning with the immediate family (parents, siblings, relatives), faith community (faith leaders, fellow believers, friends), formal education community (teachers, peers, friends), wider community (workmates, friends). In all the relationships we enter into, we invest emotionally but in different ways to achieve different results.

We are all born with our sex, it is God-given, and then our society trains us to adopt a particular gender expression and identity that allows us to live as we are expected by our society. This combination of our sex and our gender is what becomes our sexuality. While the majority of people combine sex and gender in conformity with societal expectations, there are others who

do not conform.

Discussion Question
What do you understand by the statement, "sexuality is biological and social"?

Day Two: Creation and Human Sexuality (Genesis 1: 26-28)

Yesterday we learnt what we mean by "human sexuality", today we want to learn about human sexuality from the Bible. Today, we are going to read Genesis 1:26-28 and from this text, we will learn what sexuality is, in the grand plan of God. We believe that the Bible provides us with answers to all our questions, the answers can be direct, but they can also be indirect. With wisdom and the guidance of the Holy Spirit in studying the Bible, however, we can always find guidance from the Bible.

Then God said, "***Let us make humankind in our image***, according to our likeness; and let them have dominion over the fish of the sea, and over the birds of the air, and over the cattle, and over all the wild animals of the earth, and over every creeping thing that creeps upon the earth." So, ***God created humankind in his image***, in the image of God ***he created them; male and female he created them***. God blessed them, and God said to them, "***Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth***."

This text is known as the "creation story" which relates how everything was called into existence by God at the beginning of time. There are important lessons that we can learn from this text.

What are our lessons today?

- ✓ According to this text, male and female combine to make up humankind, that is, people or human beings(Gunda, 2017).
- ✓ Sexuality is a gift from God to all human beings because people were created into a relationship (male and female) covering all human beings, including the intersex.
- ✓ While Christians have previously considered sexuality to be dirty or evil or sinful, sexuality is actually part of the totality that make human beings the image of God, meaning our sexuality is part of what makes us "children of God."
- ✓ According to this text, there are two main elements to our sexuality – the sex component, represented in the text by male and female and the social component, represented by the community of men and women, seen in the instruction to steward the universe.
- ✓ In relationship, human beings will steward the universe and all that is in it, in air, on land and in water!

- ✓ Procreation is another of the uses of human sexuality. God blesses human beings with the gift of multiplying, but it is not the only use of sexuality.

In short, on the basis of Genesis 1, male and female are equal but different. They are partners! While we may want to magnify the difference and minimize the equality, this text does not consider the differences to be more important than the equality that comes with being in possession of the Image of God(Gunda, 2019).

One component of human sexuality, that is, sex, is gifted to all human beings by God from creation. The Bible speaks of male and female, but it does not mean that the intersex is not created by God. The Bible explicitly mentions the two dominant forms of human sex, but such designations must not be used to deny the intersex their rightful place in the house of God. All human beings are created in the Image of God and their sex is a critical component of being an Image of God.

Discussion Question
How does Genesis 1:26-28 represent human sexuality?

Day Three: Companionship and Human Sexuality (Genesis 2:18)

Yesterday we read Genesis 1:26-28, today we want to go ahead and read Genesis 2:18 to learn about human sexuality again from the Bible. Before focusing on verse 18, please read Genesis 2 as a whole. Then the LORD God said, "***It is not good that the man should be alone; I will make him a helper as his partner***."

This text above is given when God has created the heavens and the earth, created a man (in this case, a male only) and provided a garden to be the living space, source of food and an opportunity for work, for the created male. Yet, this text suggests something was not right with this arrangement!

What are our lessons today?

- ✓ The loneliness of Adam, the male, the man, was considered not good by God.
- ✓ The loneliness of Adam could be cured by providing "companions" to remove loneliness.
- ✓ Creatures of the universe were created to cure the loneliness of the man, Adam, but the loneliness was not cured totally, it remained!
- ✓ God decides to create a helper equal to the man, and created woman, Eve, to be the helper.
- ✓ Helper in Genesis 2 has the effect of meaning "corresponding to, equal of." In the Old Testament, the helper is always "superior" to the helped, however, in this text, "the

helper, who is usually one more powerful, is here intended to be a helper-a deliverer-who is otherwise equal (rather than superior) to the human being"(Wilfong, 1988).

- ✓ The man, Adam and the helper, Eve, are equal companions to help each other in living in the garden as well as having children. The helper is not created to have children, as the primary motive, rather, she is created to provide companionship.
- ✓ Companionship or being in a mutually respectful relationship is a central part of human sexuality.

Companionship comes to all human beings throughout their lives as a very important aspect of being human. Companionship is given to children by their parents and their siblings, and as they grow older, they will get companionship from friends and other persons they encounter in the faith community and at school. As they continue to grow older companionship comes also from people they work with and the persons they share intimacy with. Companionship is not only about intimate relationships, it is about being a relational human being, as we were created as relational human beings. Throughout one's life, companionship is provided by people of one's own gender and sex as well as persons of the other gender and sex. Companionship is a human need!

Discussion Question
What is the primary motive for intimate relationships?

Day Four: Procreation and Human Sexuality (Genesis 1:28a)

Today we want to revisit Genesis 1:28 to focus on the matter of procreation and human sexuality. Procreation refers to the process of producing children. There is no denying the importance of procreation as a part of human sexuality, the question is, is it the only reason for human sexuality?

- ✓ Genesis 1:26-28 is not significant for the first section of Genesis alone. Its themes pervade the entire book. As the first book of the Bible, Genesis is the seedbed for a multitude of themes that are developed throughout the rest of the Bible. Nevertheless, James McKeown argues that standing out among all the themes of Genesis are three "unifying themes." Notably, the three unifying themes that McKeown identifies first occur together in Genesis 1:26-28: seed, land, and blessing(Collins, 2018).
- ✓ While some sections of Genesis develop additional themes, the themes of seed, blessing, and land are clearly the three unifying themes of the entire book. Thus, one could say that thematically the entire book of Genesis flows from Genesis 1:26-28. That being the case, one could argue that Genesis 1:26- 28 is the most significant set of verses for establishing the theology of Genesis(Collins, 2018).
- ✓ Seed is the theme that touches on procreation. According to Genesis and the Bible, in

general, having children is important in order to occupy land and to work the land that God has given to human beings. Procreation is a blessing conditioned by the availability of land.

- ✓ While procreation is given as a blanket blessing for all human beings, human life, both in the Bible and in our lives, shows that there are some human beings who will not live out this blessing either because of a special vocation or because of a special incapacitation.
- ✓ Not being able to procreate does not take away sexuality from those so affected! They remain in need of companionship and support!

Discussion Question
Sexuality is the same as procreation! Discuss the validity of this statement.

Day Five: Life Skills and Human Sexuality

As we end our week of learning human sexuality, today we want to focus on life skills! How can we assure ourselves and all others, healthy relationships that allow believers to preach in word and deed?

"Life skills are the strategies, abilities, expertise, or competences that enable human beings to develop positive attitudes and responsible behaviours, leading towards a healthy lifestyle and healthy relationships. As such a life skill refers to a person's ability or competence".

- ✓ Life skills are a set of human skills acquired via teaching or direct experience that are used to handle problems and questions commonly encountered in daily human life.
- ✓ Life skills refers to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life (Nyoni, Gunda, & Chitando, 2018).
- ✓ In every religious community, sexual behaviour is confined to certain interpersonal relationships, and it is when imparting this skill that religious leaders can creatively and imaginatively integrate the skill with the teaching of the religious community. Highlighting the fact that positive sexual behaviour can only be realized when committed relationships have been established and when the blessings of the community have been sought and received.
- ✓ Sexual activity can be recognized as secondary to other needs, such as friendship, trustworthy partnership, emotional bonding and support. These primary considerations in interpersonal relationships will help adolescents and young people to evaluate their relationships and make appropriate decisions regarding sexual activity (Nyoni, Gunda,

& Chitando, 2018).

- ✓ Life skills include the ability to make decisions, to communicate effectively, to assert one's position and to defend it, to resist peer pressure, to be comfortable with one's identity, to respect others including alternative opinions and views, the ability to listen etc.
- ✓ Life skills are important for healthy relationships meaning they are important for human sexuality.
- ✓ Life skills must be taught and learned by everyone, from an early age and must always be put into practice throughout one's life.

Discussion Question

What are life skills? Where can one learn these skills?

UNIT FOUR:
HUMAN SEXUALITY, ADOLESCENTS AND YOUNG PEOPLE'S SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (SRHR) IN THE CONTEXT OF THE HIV EPIDEMIC

Unit Description

This course foregrounds the importance of doing ministry through paying attention to human sexuality which is one of the most elusive and often evaded topics by religious leaders. It highlights the crucial need for effectively addressing this topic in religious circles, paying particular attention to the SRHR needs for adolescents and young people. The course also illustrates the interconnection between SRHR issues, sexual and gender-based violence and the HIV epidemic in Africa.

Unit Purpose

The main purpose of this course is to provide a platform for deliberating on how African religious leaders can effectively minister to their communities' SRHR needs in the context of the HIV epidemic. Cognisant of the fact that adolescents and young people's SRHR needs have not always received adequate attention in most African faith communities, making them more susceptible to the HIV epidemic, the course pays particular attention to this underserved group.

Unit Objectives

At the end of the course, learners will increase the knowledge and skills that will enable them to:

1. Examine the common African religio-cultural norms and values shaping perspectives on human sexuality and their impact on the HIV epidemic
2. Address the pertinent SRHR needs in their communities with a specific focus on adolescents and young people in light of the HIV epidemic
3. Identify and address the specific SRHR needs for underserved groups in their communities including young women and girls, people living with disabilities, out of school youth and the LGBTQI (sexually diverse) community
4. Provide Comprehensive Sexual Education (CSE) which caters for the diverse needs of their community with a specific focus on the adolescents and young people
5. Devise effective and practical strategies towards turning churches into safe spaces for accessing CSE and SRH as cornerstones for turning the tide of the HIV epidemic in Africa.

Unit Outline

- Day One: Introduction: Human Sexuality and SRHR
- Day Two: Adolescents and young people's SRHR in the HIV epidemic era

- Day Three: The nexus between the SRHR needs for underserved groups and the HIV
- Day Four: Comprehensive Sexuality Education (CSE) for adolescents and young people
- Day Five: Aligning SRHR with the theology of human dignity and bodily integrity as launch pads for halting the HIV epidemic in Africa

Day One: Introduction; Human Sexuality and SRHR

Human beings are sexual beings, however, in most African cultures, including the religious spaces such as the church or the mosque, religious leaders tend to be evasive when it comes to addressing the subject of human sexuality. In essence, when it comes to the subject of sex and sexuality, more often than not, religious people tend to put a heavy lid on the subject. This elusive attitude towards the subject of human sexuality has been aptly described by some African women theologians who critique religious people for focusing on engaging in sex whilst avoiding to discuss the subject of sex. The secrecy and ambivalence with which the subject of human sexuality is treated seems to have been mainly influenced by the numerous religio-cultural myths and taboos shrouding the topic within most African communities. It is therefore regrettable that instead of getting credible and life-giving guidance on the subject from their faith communities, members, especially the adolescents and young people, have been left fumbling in the dark. This paucity of relevant information and the lacuna in guidance on the subject of human sexuality has unfortunately made some individuals susceptible to either sexual abuse or irresponsible sexual behaviour. All these have provided fertile ground for the spread of the HIV epidemic. Resultantly, the HIV epidemic is often epitomized by the face of a young African woman. Hence, it is important to demystify the religio-cultural myths surrounding human sexuality so as to be equipped with relevant, scientific, life-enhancing and life-saving knowledge especially in the era of the HIV epidemic and other sexually transmitted infections (STIs).

Definitions of Key Terms on SRHR and the HIV epidemic

Sexual and Reproductive Health (SRH) is a state of physical, emotional, mental, and social well-being in relation to sexuality and reproduction. It is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences.

Reproductive health therefore implies that:

- The rights of men and women should be informed.
- People are able to have a satisfying and safe sex life.
- They have the capability to reproduce and the freedom to decide if, when and how often to do so.

- They have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law.
- The right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Although sexual health is defined in terms of well-being, it is challenged by the social, cultural, and economic realities faced by women and men living with HIV.

Sexual rights (SR) embrace human rights that are already recognized in national laws, international human rights documents, and other consensus statements. They include:

- The right of all persons, free of coercion, discrimination, and violence to the highest attainable standard of sexual health.
- Access to sexual and reproductive health care services.
- Freedom to define their own sexuality, including sexual orientation and gender identity and expression.
- Having their bodily integrity, privacy and personal autonomy respected.
- Deciding whether, when and whom to marry.

A sexual rights approach puts women and men with HIV in charge of their sexual health. Accurate, accessible information to make informed choices and safe, pleasurable sexual relationships possible is best delivered through peer education and health professionals trained in empathetic approaches to sensitive issues.

Reproductive health care is a constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. Reproductive health eludes many of the world's people because of such factors as:

- Inadequate levels of knowledge about human sexuality
- Inappropriate or poor-quality reproductive health information and services
- The prevalence of high-risk sexual behaviour
- Discriminatory social practices
- Negative attitudes towards women and girls
- The limited power many women and girls have over their sexual and reproductive lives.

Adolescents are particularly vulnerable because of their lack of information and access to

relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

Adolescents and young people's SRHR- young people, especially those living with HIV, need appropriate sexuality education and support for dealing with sexuality and self-identity with HIV. Women and men with HIV need condoms, appropriate services for sexually transmitted infections, sexual dysfunction and management of cervical and anogenital cancers. Interventions based on positive prevention, which combine protection of personal health with avoiding HIV/STI transmission to partners, are recommended.

Comprehensive Sexuality Education (CSE) covers a broad range of issues relating to the physical, biological, emotional and social aspects of sexuality. This approach recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy. It provides children and young people with culturally relevant and scientifically accurate information. CSE programmes should be adapted to the age and stage of development of the target group.

Discussion Question
Reflecting on your context, identify the religio-cultural traditions impacting on people's SRHR.

Day two: Adolescents and young people's SRHR in the HIV era

Adolescence is the period in life when an individual is no longer a child, but not yet an adult (the WHO defines adolescents as those people between 10 and 19 years of age). It is a period of drastic physical and psychological changes, as well as changes in social expectations and perceptions. Physical growth and development are accompanied by sexual maturation, often leading to intimate relationships. The individual's capacity for abstract and critical thought also develops along with a sense of self-awareness. Although adolescence is a phase and not a fixed time period, the following categories can be used to better understand the timing of these changes in terms of their sexual development.

- **Early adolescence** (10-13 years)- self exploration and evaluation
- **Middle adolescence** (14-16 years)- preoccupation with romantic fantasy; testing ability to attract the opposite sex
- **Late adolescence** (17-19 years)- forms stable relationships, mutuality and reciprocity; plans for the future

Adolescents and young people's SRHR and their vulnerability to HIV

The HIV epidemic has hit Africa harder than any other continent. No community has been able to escape this epidemic. Young people have been always regarded as the future of the continent. Yet, when it comes to their reproductive health, a number of taboos blur the vision of society. Facts are strong-headed, and they speak for themselves: 90% of the young men and 50% of young women have had sexual activities before they reach the age of twenty. **(Source?)** However, neither families, schools nor faith communities prepare them in terms of their SRHR. The result is that 20% of births are attributed to adolescents aged 15-19. Since adolescents comprise the bulk of the sexually active and reproductive cohort, this increases their vulnerability to HIV infection. Dealing with the issue of adolescent reproductive health is one of the cornerstones for turning the tide of the HIV epidemic in Africa. The key to achieving this goal is through the establishment of Youth Friendly Services where young people participate in the design and implementation of relevant SRHR programmes.

This entails:

- Providing factual information on reproductive health and sexuality.
- Respecting values, decisions, and experiences of young people.
- Maintaining privacy and confidentiality.
- Paying attention to the needs of young people.
- Providing space and time for young people to talk and ask questions in a safe and comfortable environment.

When young people make decisions based on accurate and appropriate information, they feel a sense of satisfaction and feel capable of adopting healthy behaviours. Young people may have to face many difficult decisions, and the more factual information they have, as well as a supportive environment to discuss options, the easier it can be for them to make such decisions.

The following are examples of the kinds of decisions young people may face:

- How to discourage and prevent unwanted sexual advances.
- Whether or not and when to engage in sexual relations.
- How to prevent pregnancy and STIs, including HIV.
- How to address sexual abuse or violence.
- Whether or not and when to conceive a child.
- What to do if they become pregnant unintentionally.
- What kind of antenatal care to seek and where to go.

All these factors are pivotal towards ensuring that the young people's SRHR needs have been catered for and by so doing, it enhances their capacity either to prevent HIV infection or to manage their health if they are already living with HIV.

Discussion Question

With particular reference to your context, identify the challenges encountered by adolescents and young people in terms of their SRHR and suggest how these can be addressed in light of stemming the tide of the HIV epidemic.

Day Three: The nexus between the SRHR needs for underserved groups and the HIV epidemic

Vulnerable and key populations in Southern and East Africa (SEA)

Southern and East Africa (SEA) remains the region most affected by the HIV epidemic. It accounts for:

- 47% of the world's HIV infections
- 54% of people living with HIV globally.
- About 800 000 people in SEA were infected with HIV in 2018.
- Approximately 310 000 people died of AIDS-related illness.
- Young women (15-24) accounted for 26% of new HIV infections
- An estimated one quarter of new infections were among key populations and their sexual partners.

Vulnerable and key populations include:

- Populations that live in poverty without access to safe housing, water, sanitation and nutrition
- Those who are stigmatized, discriminated against, marginalized by society and even criminalized in law, policy and practice.

These populations may struggle to fulfil their human rights, including their rights to access health and social services.

- They live in environments of inequality where they are unable to thrive, feel safe and actively participate in all aspects of society.
- Communicable diseases such as HIV, TB and malaria, and non-communicable diseases such as cancers, may disproportionately impact vulnerable and key populations.

These factors infringe on their SRHR, this increases their vulnerability to the HIV epidemic. The following are some of the vulnerable and key populations:

- **Children**- Although the number of new HIV infections amongst children is decreasing, they continue to lag behind adults in access to ART.

- **Young women and girls**- Adolescent girls and young women in SEA are disproportionately affected and young women (aged 15–24 years) accounted for 26% of new HIV infections in 2016 despite making up just 10% of the population.
- **Out of school youth**-they often fall through the cracks since most of the SRHR and HIV interventions focus on school-going youth
- **People living with disabilities**-countless myths perpetuate the belief that they are either not sexually active or that engaging in sex with a person living with disability activates some magical powers. This increases their vulnerability to either being sexually abused or to being excluded from SRHR and HIV interventions
- **LGBTQI people**- they are at a higher risk of HIV exposure in SEA. In 2019, the vast majority of countries in SEA were on record for criminalising same-sex sexual conduct for men and women.
  - Some governments, political and religious leaders promote homophobia and discrimination against people on the grounds of their Sexual Orientation and Gender Identity (SOGI).
  - Young LGBTQI people reported homophobia and/or transphobia amongst school administrators and teachers and limited access to remedies from bullying, harassment, discrimination, and other rights violations.
  - Acts of violence are often committed by family members or others who perceive the individual's sexual orientation or gender identity as inconsistent with social or cultural expectations
- **Sex workers-** they continue to experience violations of their human rights, particularly, discrimination and violence. This increases their vulnerability to HIV, with little access to justice, in countries in SEA.
- **People who use drugs**- According to the Kenyan AIDS Strategic Framework for 2015/6 – 2018/9, people who inject drugs account for almost 4% of all new HIV infections in Kenya.
- **Prisoners**- Research suggests the risk for prisoners contracting HIV and TB to be as high as ten times the risk for the general population
- **Internally Displaced Persons or Refugees**- their insecure accommodation spaces and limited access to basic amenities impinges on their ability to access SRHR and HIV interventions, this increases their vulnerability to sexual abuse.

The above underserved, vulnerable and key populations remain highly vulnerable to HIV and have high levels of unmet SRH needs. This presents a challenge to all people of faith who are committed towards transforming society to implement measures that can redress these gaps.

Discussion Question

Identify specific interventions that can be implemented by your faith community to address the SRHR needs for the vulnerable and underserved groups in your context and explain how such interventions can contribute towards stemming the tide of the HIV epidemic.

Day Four: Comprehensive Sexuality Education (CSE) for adolescents and young people

CSE is a key component of a holistic approach to adolescent SRHR, particularly in light of the HIV epidemic. It helps adolescents and young people to understand how to:

- Protect and promote their sexual health and wellbeing.
- Prevent unintended pregnancies, STIs including HIV and reproductive health risks such as cervical cancer.
- Get treatment and care for illnesses.

As a rights-based and gender focused approach to sexuality education, CSE seeks to equip young people with the knowledge, skills, attitudes, and values they need to determine and enjoy their sexuality-physically and emotionally, individually and in relationships. The CSE approach:

- Views sexuality holistically, as a part of young people's emotional and social development.
- Appreciates each person's unique identity, including social, cultural and economic differences.
- Recognizes that information alone is not enough. It affirms that young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.
- Leads to improved knowledge, increased condom use, decreased multiple partners, better understanding of HIV prevention, and delays in initiating sex and better attitudes towards safer sex.

Due to its pivotal role in addressing the SRH needs as well as curtailing the impact of the HIV epidemic, CSE should be made accessible for all young people, including adolescents both in and out of school.

Discussion Question

Focusing on your context, identify the key areas that your faith community needs to improve in terms of availing Comprehensive Sexuality Education for adolescents and young people.

Day Five: Aligning SRHR with the theology of human dignity and bodily integrity as launch pads for halting the HIV epidemic in Africa

There is resonance between the key concerns raised by the advocates for SRHR and the arguments raised by the proponents for a theology of human dignity and bodily integrity. Both affirm that life is a sacred gift which deserves to be protected and preserved. Hence, denying others access to safe and equitable access to SRH as well as exposing others to the vulnerability of HIV runs contrary to the principle of humanity as having been created in God's image. It also refutes the central goal of Jesus' mission as summed up in John 10: 10, "I have come that they may have life, and that they may have it more abundantly." By failing to be proactive in redressing the status quo which denigrates the adolescents, young women, the elderly, people living with disabilities and all other underserved and vulnerable populations to the vulnerability of HIV whilst denying them access to their SRHR, religious people will be liable to the sins of commission and omission. It is tantamount to denying these vulnerable groups their having been created in *imago dei*. Hence, if religious leaders and all people of faith affirm that all human beings have been "fearfully and wonderfully made" (Psalm 139:14), then there is no excuse for looking aside when young women and girls are exposed to various forms of gender-based violence which barricade them from accessing life-saving SRH. Perpetuating stigma and discrimination on fellow human beings on the basis of their gender, social class, age or any other defining characteristics would be in essence refuting their humanity and dignity.

There is therefore need for all people of faith to speak with one prophetic voice, denouncing all the death-dealing and life diminishing forces which deny others access to SRH and HIV interventions. This beckons the church to become a safe space where people from their diverse contexts turn to the church for CSE, SRHR and all the essential services to address the HIV epidemic. Hence, the church should endeavour to become an HIV competent and a prophetic church which speaks on behalf of the survivors and victims of gender based violence and all those whose rights have been violated. In unison with Christ, the healer par excellence, the church must be equipped to heal both physical and emotional scars.

Discussion Question

Discuss the challenges encountered in celebrating the humanity and dignity of vulnerable populations in your community and suggest ways in which your church can become a safe space for accessing SRH services and HIV interventions.

UNIT 5:
SOCIO-ECONOMIC CONSEQUENCES OF HIV & AIDS

Course description

This course discusses the socio-economic consequences of HIV & AIDS, their determinant factors and means of addressing them.

Course Purpose:

The purpose of this course is to equip students with a comprehensive understanding of the social and economic implications of the HIV & AIDS pandemics on individuals, families and communities. With such a comprehensive understanding, the students would be in position to respond to these socio-economic challenges in a way that minimises the impact of HIV and AIDS on individuals and the community.

Course objectives

At the end of the course, you will be able to:

- To describe the social and economic consequences of HIV and AIDS on individuals, families and communities
- To equip students with knowledge about the social, economic and political factors that influence the socio-economic consequences of HIV & AIDS
- To equip the learners with knowledge and skills required to practically respond to the social and economic consequences of HIV & AIDs

Outline

Day 1: Introduction
Day 2: Socio-economic consequences on People Living with HIV
Day 3: Socio-economic consequences on communities
Day 4: Factors influencing the socio-economic Consequences of HIV & AIDS
Day 5: Addressing the socio –economic consequences of HIV & AIDS

Day 1: Introduction

Overview of Socio-economic consequences of HIV & AIDS

Socio-economic consequences of a pandemic basically refer to its social and economic repercussions. Since its outbreak in 1981, HIV & AIDS has affected people in every part of the world in various ways, imposing significant social and economic implications on not only the people living with HIV but also their families and communities at large. Social consequences refer to those consequences that affect intrapersonal and interpersonal relationships. They include issues to do with spirituality or religious state, social identity, the gender dynamics of the pandemics access to social services among others. Economic consequences relate to

financial aspects and economic productivity. There is a very close and mutual relationship between social and economic affairs and social and economic factors always interact with each other. Over time, HIV & AIDS has evolved into a complex social and economic emergency affecting people of all age groups, social status, race, and colour. The pandemic is of great concern to people living with HIV and those who are HIV seronegative. According to UNAIDS indications, HIV infections seem to be finding a new breeding ground in children, adolescents, and young people in Sub-Saharan Africa given the rapid and unexpected growth of the HIV seroprevalence rate among these segments of the population. This is a very devastating reality in Sub-Saharan Africa given that children, adolescents, and young adults dominate the region's population and are major stakeholders in its social and economic affairs. This population group, therefore, needs special attention when interrogating the socio-economic of the HIV pandemic.

Discussion Questions

a. *Why is it important for faith leaders to understand the socio – economic consequences of HIV & AIDS?*
b. *Describe three ways through which the socio-economic consequences of HIV and AIDS among children, adolescents and young adults can be identified.*

Day 2: Socio-economic consequences on People Living with HIV

People living with HIV experience numerous socio-economic challenges that can only be understood when they share about their experiences, and these can be categorized into three: Lifetime dependency on ART, Sexual and reproductive health challenges, and HIV-related Stigma.

Lifetime dependency on ART

HIV & AIDS cure has not yet been discovered and people living with HIV have to depend on Anti-Retro Therapy to suppress the viral load and adapt a healthy lifestyle. Without ART, the person living with HIV can develop AIDS, a condition that weakens the body and makes one less productive at work and in other social activities. Although in many context ART medicines are given free of charge to the people living with HIV, People living with HIV still require resources to access facilities where ART and other necessary HIV services are provided and also to be able to have a health nutrition.

Sexual and Reproductive health challenges

This category includes Sexual & Gender-based Violence (SGBV) and sexual and reproductive relationship issues among others.

In many contexts, People living with HIV experience gender-based violence in from of

domestic violence, and denial of financial support from their partners and spouses, among others. In most cases, these acts of violence are perpetrated against them as a way for punishing them for living with the virus. SGBV imposes significant financial costs on the victims usually incurred in the process of seeking for justice and treating the wounds left behind by acts of domestic violence. It also damages the survivors' self-esteem making it hard for them to successfully relate and fully interact with other people

As far as sexual and reproductive relationships are concerned, many people living with HIV face numerous challenges in establishing successful intimate relationships. Due to the availability and use of ART, there are thousands of young people living with HIV who have grown to reproductive age, and just like all other human beings, they desire to engage in sexual relationships. They fall in love and many of them attract the feelings and attentions of other people who wish to establish romantic relationships with them. However, in some contexts, establishing a romantic relationship especially with people who are HIV negative is a challenge since at times disclosure about ones' positive HIV status can cause the HIV-negative partner to opt out of the relationship.

The other issue here is the cost of safe sex tools. Sexually active People living with HIV, are encouraged to use safe sex tools like condoms correctly and consistently to minimise co-infections and new transmissions. In some contexts, however, accessing these tools has financial implications that they may not be able to meet. In situations when free condoms are out of reach, the people who need them must spend money to obtain the ones sold in pharmacies and shops.

HIV related stigma

Stigma is a main socio-economic consequence of HIV & AIDs on people living with HIV. This stigma manifests in two forms; self-stigma and public stigma.

Self-stigma is internal stigma whereby the person living with HIV hold negative attitudes, perceptions and blames towards themselves as a result of their HIV status. Self-stigma also destroys a person's confidence and makes it difficult for them to relate with other people effectively.

Public stigma is the discrimination that other people direct towards people living with HIV. Where this kind of stigma exists, people living with HIV are discriminated against in: the provision of social services, the distribution of economic resources, employment, accessing education services, accessing human rights, among others.

Stigma also affects treatment adherence and if the person living with HIV defaults from taking

the ARVS they may develop other health complications rendering them unproductive economically and instead they eat on the available resources in search for treatment. Stigma also hinders people living with HIV from adapting SAVE and therefore continues to fuel new HIV infections, which continues to have adverse negative effects on the population economic growth.

Discussion question
How does HIV self-stigma and public stigma hinder the economic growth of people living with HIV?

Day 3: Socio-economic consequences on communities

The socio-economic consequences of HIV & AIDS on communities are very diverse and they include the following

Increased expenditures health services

The HIV and AIDS pandemic strains every community's economic resources since a significant portion of these resources must be directed towards addressing the pandemic by putting in place HIV services, procuring HIV medications and other health devices, creating awareness on the pandemic, among others.

Impended economic growth

Where people living with HIV develop AIDS and are not able to work as productively as they ought to be, where people lose their loved ones to AIDS-related deaths and end up experiencing mental challenges, where people living with HIV and people affected by HIV are stigmatized and thus fail to engage in income-generating activities or community development projects, the community's economic growth impede.

Conflicts and Violence

The HIV & AIDS pandemic accounts for the existence of various kinds of conflicts and acts of violence. Conflicts manifest among people who bear stigmatizing attitudes towards people living with HIV and they feel uncomfortable to associate with them in any way. Conflicts are also common in families where one member is accused of bringing HIV in the home, where some community members intentionally desire to spread the HIV Virus to others through sexual violence, etc. In some communities, families of people known to be living with HIV have suffered mob justice perpetuated against them by other community members. There is also a strong link between HIV & AIDS and SGBV. At times people living with HIV have been targets of sexual abuse and domestic violence.

Increased Vulnerabilities among the children and elderly

Many communities and families have lost people to AIDS-related deaths within their productive age leaving their communities seriously understaffed in production areas. In other communities, people succumb to AIDs and leave behind young children who need to be provided for by elderly people who are already past their productive age. Having lost the productive generations, such communities have witnessed cases of child labor, as young children heading their families are forced to work to sustain their siblings. Elderly people also continue to work past their pensionable ages, as they seek to sustain their grandchildren which exaggerates the health challenges they face in old age.

Discussion question

Discuss the socio-economic consequences of HIV and AIDS on your faith community

Day 4: Factors influencing the socio-economic Consequences of HIV & AIDS

As discussed in the previous two days, the socio-economic consequences of HIV & AIDS are diverse, and they are experienced by all kinds of people: People living with HIV and people who are HIV negative. They are also experienced at individual level and also at community level. However, the extent to which these consequences are experienced by individuals and communities depends on a number of social, economic, and political factors. Some of these actors are Ignorance Illiteracy, Cultural values, norms & Practices, Religious values, norms & practices, political situation, economic status, corruption and emergency situations. Much as each of these factors affects influences the socio-economic consequences of HIV & AIDS in a unique way, the factors are all interrelated in one way or another.

Ignorance

Ignorance (lacking basic facts and knowledge) about HIV and AIDS influences the level of HIV stigma prevalent among individuals, in a community and within people leaving with HIV. Ignorance thrives on many factors that include the limited accessibility to accurate knowledge and information about HIV and AIDS. the levels of ignorance on HIV & AIDS issues varies from individual to individual and from community to community and the higher the level of ignorance the greater the greater the socio-economic consequences of the pandemic. For instance, people who possess accurate knowledge about HIV and AIDS are less likely to perpetuate HIV stigma as compared to those who lack the same knowledge.

Illiteracy

Illiteracy is the inability to read and write. It is a great barrier to communication in the

contemporary world where much of the communication is done through writing. For example, people who do not know how to read and write cannot make sense of the written prescriptions and instructions on medications, posters, etc. Communities with high illiteracy levels are also usually characterised with high levels of ignorance on HIV & AIDS.

Cultural values, norms & Practices

Cultural values, norms and practices influence how the HIV & AIDS pandemic is socially perceived and responded to by adherents of a specific culture. In communities where the pandemic is perceived as a consequence of curses from spirits and ancestors, little or no effort would be made to ensure the wellbeing of the people living with HIV and people affected by HIV since they would be perceived as people who deserve the suffering they experience. Cultural practice that increase vulnerability to HIV also play a significant role the continued spread of HIV which in-turn intensify its socio-economic consequences.

Religious values, norms & practices

Just like culture, religion influences the way the HIV & AIDS pandemic is perceived, the attitudes with **it sis** responded too. Religion influences the way people living with HIV interpreted their circumstances. It also influences peoples' attitudes and behaviours towards people living which HIV in the community, at work places and service delivery centres

Political situation

The political situation of the community can either intensify the socio-economic consequences of HIV or it can actually assist overcome the pandemic. For example, in areas where political conflicts are prevalent, accessing HIV medication may be a great challenge compared to a politically stable area.

Emergency situations

Emergency situations usually call for special and urgent attention and sometimes, they directly exert negative effects on HIV and AIDS management. For instance, during the outbreak of COVID 19, the enforced national lock down limited access to HIV medications and services. This had major implications of individuals and communities.

Discussion question

Discuss the impact of corruption on the socio-economic consequences of HIV & AIDS in your country

Day 5: Addressing the socio –economic consequences of HIV & AIDS

Overcoming the HIV & AIDS pandemic involves both eradicating the spread new HIV infections and also addressing its socio-economic consequences among people living with HIV and within communities as a whole. To achieve this complex task, there is need to respond to the factors that influence the socio-economic impact of HIV. There is need to respond to the challenges of ignorance, literacy, political instabilities, dangerous cultural and religious values, norms and practices, and all other factors mentioned in this unit and all that you can add on the list. This is not a simple task, but the good news is that it is possible. It is possible as long as everyone does something relevant to the elimination of those factors that account for the adverse socio-economic consequences of HIV that they know how to do best. The duty requires a great deal of resources that can only be obtained through collaborations, partnerships, and networking.

Students Activity

At this point,

A. Take a few minutes and think about the socio-economic consequences of HIV in your community and do a list outlining five of them experienced by the people living with HIV and five being experienced by your community in general.
B. List down the various factors that influence the extent to which the consequences you have listed in (A) are experienced
C. From the list you made at step B, choose two factors that you would like to respond to
D. List down the resources you think are needed to address those two factors and mark out those resources that you have and those that you do not have
E. Write down names of individuals, companies, organisations that you know have the resources you lack but need in order to respond to the two factors you chose at step C.
F. Come up with a strategy you can use to collaborate and partner with the individuals, companies, organisations you have listed in E.

Discussion question

Outline five advantages and five disadvantages of collaborations and partnerships in addressing the socio-economic consequences of HIV & AIDS

UNIT SIX:
GENDER BIBLE AND HIV

Unit Purpose

The Bible is an authoritative book of the church, guiding its life in all contexts. With the HIV/AIDS epidemic, the church seeks understanding and guidance from the Bible regarding disease, healing, stigma and isolation, guilt and fear, caring, death and dying. For the African church, as African theology underlines, the Old Testament has a significant place. The response to HIV/AIDS was thus largely interpreted within the framework of disease as punishment for an individual's sin. This approach fuelled the HIV/AIDS stigma and hampered the church's ministry to the affected and infected. This unit seeks to explore and expose the learner to various other biblical frameworks of understanding and handling disease as well as to re-read the Bible in the light of HIV/AIDS.

Unit Objectives

At the end of the course, learners should be able to:

- Identify he various frameworks of understanding disease in the Bible;
- Understanding that the framework of disease as sin is highly contested within the Old Testament (Job) and rejected by Jesus;
- Understand that healing is an unconditional God's will for all and that it is central to the ministry of the church;
- Understand that healing is an unconditional God's will for all and that it is central to the ministry of the church;
- Develop a biblical basis for fighting the stigma of HIV/AIDS;
- Utilize the prophetic framework to analyse social injustice and the biblical perspective to justice;
- Assume an advocacy/prophetic role regarding the rights of women, youth, children, PLWHA and other marginalized groups,

Unit Outline

- Day One: The importance of the Bible
- Day Two: Healing framework in the Old Testament
- Day Three: Healing framework in the ministry of Jesus
- Day Four: Healing in the early church
- Day Five: Designing a prophetic message to the HIV and AIDS context

Day One: Introduction to the Bible

Sing "read your bible pray every day"

Read your Bible pray every day, pray every day, pray every day

Read your bible pray every day if you want to grow.
If you want to grow X 2
Read your Bible pray every day if you want to grow.

Which of the following views does PCEA hold about the Bible?

i. The Bible is the literal word of God
ii. The Bible was written by a single author
iii. The Bible is the inspired word of God written down by different people over a period of time
iv. The Bible is the only source of God's word
v. The Bible and the tradition of church carry the word of God

Read 2nd Timothy 3:16: All scripture is inspired by God and profitable for teaching, for reproof, for correction, and for training in righteousness,

Why is the Bible an important text not to be ignored?

1. The Bible is central in the church in Africa
2. The Bible is quoted in events even if they are political, social economic, cultural and religious
3. The Bible is used to justify actions that people undertake e.g. gender roles
4. The Bible is used to justify stigma and exclusion
5. the Bible is important for transforming our vies and perceptions

How was the Bible produced?

The Bible as we have it today was written over a period of 1000 years and was collected together over an even longer period of time. We know its stories originated from within human societies of every possible size and shape, from small tribal villages to cosmopolitan cities. The information in the Bible reflects extraordinarily diverse circumstances. The Bible contains wide-ranging and divergent views about human values, theology and religious practice.
The contexts which informed and influenced the various writers of the bible were incredibly different from our own. In the bible we have different books of literature including laws, history, poetry, songs, proverbs, and letters. At the heart of the Bible; God's salvation as seen in the person of Jesus Christ.

How do we read the Bible?

The Bible is a human text, and just like any other human text, it comes from particular cultural contexts. There is truth, in the Word of God, in the Bible; but it comes dressed in the clothes of a particular culture, a particular worldview, and we need to make sure we can see beyond the cultural trappings to the truth that lies therein. It is like wearing a nice dress for work or

ceremony, but wear a *kanga* —a piece of printed cotton fabric—on top not to make it dirty. In the same way a *kanga* may disguise what is underneath, emphasizing on the cultural expression can contradict the underlying truth of the Bible. There is need to beyond the cultural expressions in the texts

Considering the Bible was written in particular cultural contexts and it has been in different cultures before you and I reading the Bible should be a process of stripping and re-clothing to reach to the core of the message.

Discussion Question
How does culture affect the way we read the Bible?

Day Two: Bible and HIV- Frameworks

The Bible is an authoritative book of the church, guiding its life in all contexts. The bible has varied positions about disease and not all the diseases we are dealing with are mentioned in the Bible, but it is important when looking at all diseases and their impact in society.

With HIV/AIDS epidemic, the church seeks understanding and guidance from the Bible regarding disease, healing stigma and isolation, guilt & fear, caring, death and dying.in the earlier days of the HIV/AIDS pandemic the church responded by using a framework of disease and punishment for individual's sin. This approach fuelled the HIV/AIDS Stigma and hampered the church's ministry to the affected and infected. In this section we shall use liberative biblical frameworks of understanding and handling disease as well as to re-reading the bible in the light of HIV/AIDS.

1. Framework of disease and punishment

Read these texts and write down the perspectives of disease

- ✓ Genesis. 30;
- ✓ Exodus. 1-12;
- ✓ Leviticus. 13-15;
- ✓ Num. 12, 14 and 21:4-9)
- ✓ Deut. 7:12-16 28
- ✓ 2 Samuel. 24

What are the perspectives that these texts bring out in the light of disease as punishment?

Day Three: Jesus' healing Ministry and HIV/AIDS

The ministry of Jesus is recorded in the Gospels of Mathew, Mark, Luke, and John. The Gospels record the baptism of Jesus, and the Spirit came upon him as a dove and God spoke to affirm that Jesus was God's son. (Mathew 3:13-17; Mark 1:9-11; Luke 3:21-21)

The Gospel sets out how Jesus began his ministry starting from his home place in Nazareth, he attended the synagogue on the Sabbath and read from the scroll. He went to Nazareth, where he had been brought up, and on the Sabbath day he went into the synagogue, as was his custom. He stood up to read, [17]and the scroll of the prophet Isaiah was handed to him. Unrolling it, he found the place where it is written: "The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners, and recovery of sight for the blind, to set the oppressed free, to proclaim the year of the Lord's favour." Then he rolled up the scroll, gave it back to the attendant and sat down. The eyes of everyone in the synagogue were fastened on him. He began by saying to them, "Today this scripture is fulfilled in your hearing." All spoke well of him and were amazed at the gracious words that came from his lips. "Isn't this Joseph's son?" they asked. (Luke 4:16-22).

This text that has been termed as the Nazarene Manifesto sets out the vision and mission of Jesus. Jesus follows the prophetic tradition as this text is from the book of Prophet Isaiah. Jesus reminds the listeners that the words he read were a fulfilment of what was told. From the text Jesus names his role to challenge the social injustice by pronouncing liberation to the poor, the captives and the sick. He also announces hope as he came 'to proclaim the year of the Lord's favour. This was inclusive of social and economic justice to all in the society (Leviticus 25:8-55). Out of this we see the mission of Jesus involving empowering the marginalized of the time for instance the women. He recognizes them, (he spent time talking to women (john 4:1-42) he touched them even those that were bleeding regarded as untouchables (mark 12), he brought healing and wholeness including spiritual healing: forgiving sins and welcoming social outcasts. this we can see from these healing stories

The healing stories by Jesus in the Gospels

1. Jesus cured the nobleman's son (John 4:46-47).
2. Jesus cast out an unclean spirit (Mark 1:23-28).
3. Jesus cured Peter's mother-in-law of a fever (Mark 1:30-31).
4. Jesus healed a leper (Mark 1:40-45).
5. Jesus healed the centurion's servant (Matthew 8:5-13).
6. Jesus raised the widow's son from the dead (Luke 7:11-18).
7. Jesus cured two demoniacs (Matthew 8:28-34).
8. Jesus cured the paralytic (Matthew 9:1-8).

9. Jesus raised the ruler's daughter from the dead (Matthew 9:18-26).
10. Jesus cured a woman of an issue of blood (Luke 8:43-48).
11. Jesus opened the eyes of two blind men (Matthew 9:27-31).
12. Jesus loosened the tongue of a man who could not speak (Matthew 9:32-33).
13. Jesus healed an invalid man at the pool called Bethesda (John 5:1-9).
14. Jesus healed a woman of Canaan (Matthew 15:22-28).
15. Jesus cured a deaf and mute man (Mark 7:31-37).
16. Jesus opened the eyes of a blind man (Mark 8:22-26).
17. Jesus cured a boy who was plagued by a demon (Matthew 17:14-21).
18. Jesus opened the eyes of a man born blind (John 9:1-38)
19. Jesus cured a woman who had been afflicted eighteen years (Luke 13:10-17).
20. Jesus cured a man of dropsy (Luke 14:1-4).
21. Jesus cleansed ten lepers (Luke 17:11-19).
22. Jesus raised Lazarus from the dead (John 11:1-46).
23. Jesus opened the eyes of two blind men (Matthew 20:30-34).
24. Jesus restored the ear of the high priest's servant (Luke 22:50-51).
25. Jesus rose from the dead (Luke 24:5-6).

What themes cut across the healing narratives of Jesus?

Jesus challenged the framework of disease as sin

Discussion Question

Read John *9. How did Jesus Challenge the framework of diseases as sin in this text?*

Day Four: The Healing Ministry of the Church

For the last two days we have seen how in the prophetic tradition has been used to tell of God's word. Jesus following the prophetic tradition teaches by example when he his disciples to go out and teach and heal. (Mathew 10 and 20). Before Jesus leaves the he commands his Disciples to continue the ministry earth he commands his disciples to teach people to obey all that he had taught them (Mathew 28:20).

At the inauguration of the church the Spirit was purebred "upon all flesh" of the believers giving Christians the power to speak (Acts 2:122), the fulfilment of the prophesy by Joel. "In the last days it will be, God declares, that i will pour out my spirit upon all flesh, your sons and your daughters shall prophesy... Even upon slaves, both men and women, in those days I will pour out my spirit; and they will prophecy (Joel 2:28)

The Spirit of God is on the believers to bring the Good News of Jesus Christ following in his footsteps as stated in Luke 4:18) the spirit of the Lord is upon me because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favour.

The church was inaugurated as a community to proclaim the good news where gender, class, race, age discriminating, and stigma is null and void. The church was to be a healing community in totality.

Discussion

Read the following healing texts in acts

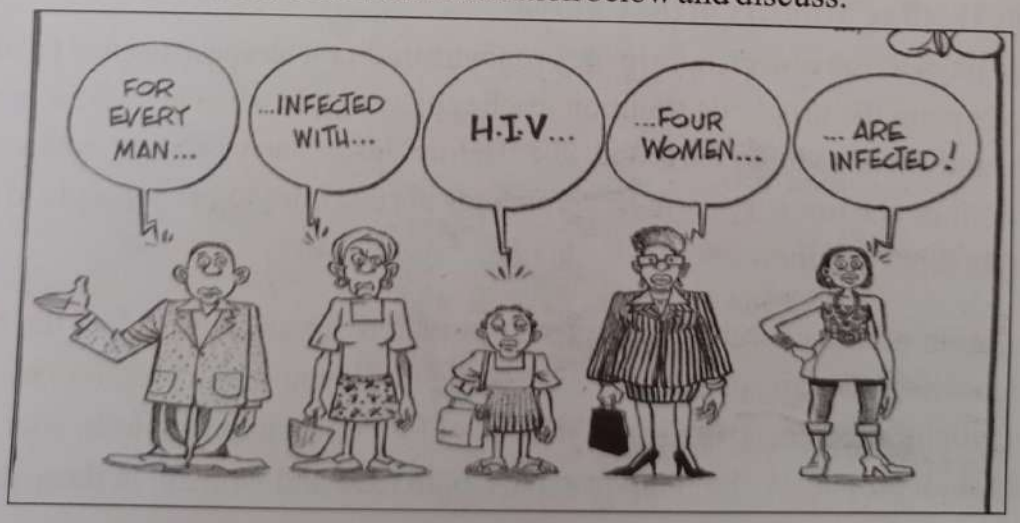
- ✓ *The Healing of Aeneas: Acts 9:32-35*
- ✓ *Paul's Healing at Lystra: Acts 14:8-10*
- ✓ *The Sons of Sceva: Acts 19:11-20*
- ✓ *Eutychus Raised from the Dead: Acts 20:7-16*
- ✓ *Paul on Malta: Acts 28:1-9*
- ✓ *The Lame Beggar Healed: Acts 3:1-10*

What healing paradigms do we deduce from the church in the book of acts?

Day Five: The prophetic role of the church and HIV&AIDS

We have seen the various ways paradigms of healing in the Bible and how the prophetic tradition is strong in the quest for justice. We have seen through the prophetic tradition and in the spirit of Jesus and the apostles that they spoke to the various situations that confronted the people of their day and brought healing and wholeness to the people. We know that we have different situations and that of HIV has brought to light many forms of Injustices.

Today we are going to prophecy in the following situation using the prophetic traditions that we have come across this week. Check the illustration below and discuss.



a) Who is this man and who are these four women?

b) Why is this an occurrence in our societies
c) Prepare a prophetic message on HIV and AIDS situation in your context
d) You are free to use a method that speaks to the realities you are dealing with

Conclusion

We began by showing how the Bible is an important text for the Christian community. We also know that there are many issues in our society that the Bible does not mention or talk about such as HIV/AIDS. However, we use the Bible to respond to these issues through reading and interpreting the bible we apply the message to many of the issues in society. In these five days we have looked at the theme of the Bible and healing in the context of HIV. The prophetic tradition of the Bible is one of the many ways of reading and using the Bible in the context of HIV.

Revision Questions

a) In what ways has this been used to approach HIV/AIDS
b) Are there ways in which these perspectives are still held by the church?

The book of Job.

The book of Job is read and used to talk about suffering. Job suffers loss at all fronts particularly loss of his children. He suffers a terrible disease and wish he was not born he could return to his mother's womb. His three friends visit with him and interrogate him about his situation confirming that this disease came to him because of some sin.

Discussion

Read these texts from the book of Job

✓ *Job1-2;* ✓ *Job 2:9-13;* ✓ *Job 3:3-37;* ✓ *Job 38-42*

a). How does Job Challenges the framework of disease and punishment?
b). What are some of the usable frameworks from Job in dealing with HIV/AIDS?

The Prophetic healing and HIV

In Hebrew the word prophet *nabi* means proclaimer. Prophets are those who proclaim the will of God for the people. In most instances the prophets were able to see the dangers that would hit the people as a result of their broken relationship with God. They would both deliver the message of God and also plead on behalf of the people. The prophets spoke harshly against injustice in the society of all kinds. They used different methods to deliver the messages of justice

Using these texts what methods did the prophets use to pass their messages?
Jeremiah 11:1-5; Jeremiah 19; Jeremiah 27; Isaiah1:2-20, 20; Ezekiel 12; Amos 5: 23-24; Micah 6:6;

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In the HIV and AIDS context there is need to take on the prophetic tradition in order to pass on the messages of challenge and hope. HIV and AIDS has brought to light many issues in our society including the hidden adherence of the cultural practices that impact on the vulnerable in the society. Together with this the economic disparities and how they impact on the infected and affected. HIV and AID has forced us to talk about Sex that was perceived as a taboo subject. HIV and AIDS has had a sharp focus on Sexual Gender based violence to name just but a few. Above all this is the misleading theologies based on the reading and interpretation of the Bible which is the focus of this section of study. In regard to healing we know that the reading and interpretation of the Bible has led many to claim healing and drop their medicines and they die.

From the prophetic traditions that you have read above what ways can we use to present the message of healing to the people infected and affected by HIV.

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In what ways can we challenge the paradigm of sin in the case of HIV /AIDS?

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What lessons can we learn about healing for the people infected and affected by HIV and AIDS?

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UNIT SEVEN:
HIV AND AIDS PREVENTION

Unit Description

This unit discusses the measures that have been proved effective in preventing the transmission of HIV and in saving the health of people living with HIV from progressing to AIDS. The faith-based approach of reducing SSDDIM and Multiplying SAVE is the HIV and AIDS prevention approach described in this unit.

Unit Purpose

The purpose of this unit is to equip learners with holistic knowledge on HIV and AIDS prevention such that they can work towards ending the spread of HIV and AIDS.

Unit Outline

1. Introduction
2. Understanding SAVE and SSDDIM
3. Access to Treatment and proper nutrition
4. Voluntary Counseling & Testing
5. Reducing SSDDIM

Day One: Introduction

HIV and AIDS prevention is all about halting the spread of HIV from one individual to another and ensuring that an HIV infection does not progress to AIDS. The most effective way to achieve this is by multiplying SAVE and reducing SSDDIM. This comprehensive approach was developed by members of the African Network of Religious leaders living with or personally affected by HIV and AIDS. These built upon the ABC (in explain) approach (that addresses only sexual means of HIV transmission) to holistically address sexual and non-sexual means of HIV transmission and other factors that fuel the spread of HIV and AIDS.

Understanding SAVE and SSDDIM Safer Practices

SAVE	SSDDIM
SAVE is an acronym that stands for all the things that must be done to halt the transmission of HIV and AIDS. These are categorized into; **S** Safer practices **A** Availability & Access to treatment (ART, and treatment for STDs and other opportunistic infections) and to nutrition **V** Voluntary and routine HIV counseling and testing **E** Empowerment with knowledge as well as economic empowerment	SSDDIM is an acronym of the six evils that fuel the transmission of HIV and AIDS. These six evils are the things that must be eliminated so as to prevent HIV and AIDS. These are; **S** Stigma **S** Shame **D** Denial **D** Discrimination **I** Inaction **M** Mis-action

These refer to all of the things that can be done to reduce the risk of HIV transmission. Some are safe sexual practices while others are non-sexual safe practices. (They include A + B + C + Safe Male Medical Circumcision (SMMC) + Prevention of Mother to Child Transmission (PMCT, etc.). These shall be explained below.

A = Abstinence

Abstinence is very helpful in HIV prevention. However, even with abstinence, one should be alert to prevent HIV transmission by non-sexual means. And utilize the provision of PEP where forced sex for example rape, apply.

B = Being mutually faithful to one faithful sexual partner

Having sex with only one partner whose HIV status is known to be HIV negative and is also mutually faithful reduces the risk of sexual transmission of HIV. However, being faithful to a sexual partner who is unfaithful or who is already HIV positive is not an effective means of HIV prevention.

C = Correct and consistent use of condoms

A condom is made from latex rubber, synthetic rubber or thin plastic called polyurethane. There are two common types of condoms, namely, the male condom and the female condom and each type when used correctly, is effective in preventing the semen from mixing with the vaginal fluid. If properly used, the condom reduces the risk of STI (including HIV) transmission and unwanted pregnancy by 100%. If a condom is defective, then its protective ability is compromised. It is therefore important to ensure that condoms are stored and handled appropriately as instructed by manufacturers. Condoms should be stored in a dry and relatively cool place, not be directly exposed to the sun, are not reusable, should never be used past the expiry date and oil-based lubricants should not be applied to them. Oil-based lubricants such as Vaseline [petroleum jelly], vegetable oil, or any other oil or grease can weaken the condom and cause it to burst during sexual intercourse. Usually there is already a lubricant in the condom packet and when the condom is removed from the packet, it will be seen that it is covered with a slippery fluid. This slippery fluid is a water-based lubricant and does not damage the condom. Condoms usually come with instructions on how to use them which are correct and easy to follow.

SMMC = Safe Medical Male Circumcision

SMMC involves the surgical removal of the tissue covering the penis glans (foreskin) done from a safe environment by a well-trained practitioner. The area under the foreskin easily scratches or tears during sex, thus providing a route for HIV to pass through. In addition to this, the region under the foreskin provides a moist dark place in which germs thrive; this makes one

more vulnerable to sexually transmitted diseases which in turn increases the risk of contracting or passing on HIV.

PMCT = Prevention of mother to child transmission of HIV during pregnancy, delivery and breast feeding. Other safer practices include Safe Blood, use of sterile body piercing objects, etc.

Discussion Question
Identify the myths and misconceptions about the use of Condoms, Safe Male Circumcision and abstinence as methods of HIV and AIDS prevention among people in your community

Day Two: Availability and Access to Treatment and proper nutrition

There are three different types of HIV treatment that can be used to prevent the spread of HIV and AIDS; Pre exposure prophylaxis, Post exposure prophylaxis and Anti-retro viral therapy (ART).

Pre exposure prophylaxis (PrEP)

PrEP is the medicine that an HIV-negative person can take before engaging in anything that puts them at risk of contracting HIV and it offers protection against contracting the virus. PrEP is recommended for people who are HIV negative but are at a very high risk of contracting the virus such as a person whose sexual partner is HIV positive, people with multiple sexual partners or whose sexual partners have multiple sexual partners and those who share sharp equipment to inject drugs. PrEP is usually administered by taking one pill per day and its correct and consistent use reduces the transmission of HIV by 99%.

Post Exposure Prophylaxis (PEP)

PEP is the medication that can stop the HIV from multiplying inside the body after a recent exposure; by killing the body cells that have been infected with HIV, thereby stopping the body from developing an HIV infection. PEP only works if one begins the medication within 72 hours from the time one is exposed to contracting HIV. At times PEP may not work more so if the medicine is not taken early enough and correctly. Circumstances when PEP can be opted for include incidents when one has been exposed to HIV during sex e.g. if a condom breaks or slips off during the intercourse, when one has been sexually assaulted (raped) and when has been injured with an HIV positive sharp equipment expected to be carrying the HIV. The medicine is administered every day for 28 days.

Note: Before starting PrEP or PEP treatment, one should visit a health care provider HIV testing to confirm that they are HIV negative and for proper prescription in case they are found to be in need of the treatment. For PEP one has test for HIV again at the end of the treatment to see whether it has been successful. In case a person is found to be HIV positive after taking PEP, that person should begin ART as soon as possible.

Anti-retro viral therapy

ART limits the function of HIV in the body by preventing its multiplication and reducing its amount. This enables the immune system to make more white blood cells (CD4) and to ably defend the body against opportunistic diseases.

When ART is used correctly and consistently, it results into viral load suppression; where the amount of HIV copies per unit volume of blood reduces to the possible lowest level. Effective ART can reduce the viral load to such a low level that the HIV in one's body cannot be detected by the standard blood tests. Such a viral load is referred to as an undetectable viral load. With an undetectable viral load, one cannot pass on HIV through sexual means and the risk of developing AIDS is greatly reduced. However, it does not mean that one has cured from HIV. Even when a person achieves an undetectable viral load, it can still change if that person fails to continue adhering to ART. One's viral load starts to reduce when one begins ART but it takes time for the undetectable viral load to be achieved (usually six months for people who correctly use and adhere to their ART though this time can differ from person to person).

Additionally, people living with HIV should always access treatment for any opportunistic infection they get and regardless of one's HIV status, one should always access treatment for any STI. It is also crucial for people living with HIV and every one to access the proper nutrition and feed on a balanced diet such that the body is supported by all the necessary nutrient for its wellbeing.

Discussion Question

Abel has been on ART for eight years now but he has never achieved an undetectable viral load, yet many people living with HIV are able to achieve an undetectable viral load within six months on ART. What do you think accounts for the reality of people like Abel?

Day Three: Voluntary Counseling & Testing

HIV status awareness

Voluntary testing and counselling is the first step to linkage into HIV care and support. An individual's knowledge of his or her HIV sero-status is fundamental in preventing the spread of HIV a. A person who knows his or her HIV status stands in a better position to make informed reproductive and sexual health choices. The only way one can know his or her HIV status is when he or she does a medical HIV test. Currently, both invasive (blood based) and noninvasive (oral fluid based) HIV testing services exist in Kenya and other parts of the world, and everyone has the liberty to choose their preferred method.

Disclosure

For people in sexual relations, knowledge about their partners' HIV status is equally important to them. One can learn about another person's HIV status through disclosure but if disclosure of HIV positive status is done in an unsafe environment, it may come with many challenges, especially when information about ones HIV-positive status is misused.

Empowerment

Empowerment refers to increasing the social, spiritual, economic, and political strength of individuals and communities. Empowering people to prevent HIV and AIDS involves equipping people with the accurate and age-appropriate knowledge and information to enable them make informed and right choices about their reproductive health and sexuality, building competence and fostering power in them to gain control over their own lives and also fight poverty and other wider social issues that increase vulnerability to HIV and AIDS.

Discussion Question

As a Christian, whom do you need to empower, and how can you empower him/her/them to ensure that those identified social issues are effectively addressed?

Day Four: Reducing SSDDIM

SSDDIM is caused by irrational fear that is usually comes from the lack of accurate knowledge, and skills to confront the HIV and AIDS pandemic. It has its roots in the norms, beliefs, doctrines, theologies, and values that govern our ways of life.

Element of SSDDIM	Description
Stigma	Refers to the negative attitudes and beliefs towards those known to be living with or affected by HIV. It exists in three forms: **Enacted stigma** – negative treatment a person known to be LWH receives from others in the family, community, or society because of his or her status. **Courtesy stigma** – stigma meted against people who relate or associate with PLWH **Internalised stigma** – when a person LWH accepts the negative messages and beliefs about HIV and applies them to him or herself. It results from our prejudice against PLWH that are not based on accurate knowledge, accurate reasoning, or actual experience. A person who stigmatizes perceives and treats the other being stigmatized as one of a less status, less deserving of full human consideration, less important and unworthy of respect and fair treatment. Those who suffer from internalized stigma perceive and treat themselves in this way as well. It is usually portrayed in the way we speak, express ourselves, our conduct, etc. Stigma makes it hard for people to test for HIV, adopt behaviors' and practices that offer protection against HIV transmission such as the use of condoms, SMC (simplify), etc. It hinders HIV treatment uptake and adherence and worsens the management of HIV infection.
Shame	Shame is a miserable feeling of disgrace or dishonour mixed with regret experienced by PLWH and those affected by HIV. It results from acknowledging other people's judgements or perceptions about ones reality of living with or being affected by HIV. It is individually felt but it is socially determined. Shameful emotions are accompanied by the desire to hide from others and consequently, they prevents individuals from presenting themselves for HIV testing, stops PLWH from being retained into care and from taking their medication, demotivates HIV status disclosure, and prevents people from taking up safe sex practices and from opening up on HIV related issues.

Denial	This is the refusal to accept something as true or real. Denial is when people do not agree that HIV and AIDS exist and it is incurable. It can also be described as a scenario when a person tests positive for HIV and refuses to accept the test results. Some people deny the existence of HIV and AIDS and they neglect the measures put in place to offer protection against HIV and AIDS. If one does not come to terms with one's HIV status, then it becomes so hard for him or her to enrol and adhere to ART and to comply with the measures that can protect him or her from developing AIDS and from passing the virus to other people.
Discrimination	Is the unfair or unjust treatment meted against and those known to be living with or affected by HIV It results from negative attitudes and beliefs around HIV and AIDS. It can be behavioural or institutional (discriminative laws) and it involves excluding people and denying them opportunities just because they are HIV positive or because they are affected by HIV, social isolation (not sitting on the same table with a person, preventing one from participating in a sport, choir, leadership, etc. with the rest), refusing to provide one a service, avoiding casual contact with them, etc. Discrimination fuels the spread of HIV and AIDS the same way stigma does.
Inaction	Inaction is the refusal, failure or reluctance to take the initiative to either solve HIV and AIDS related challenges or mitigate their impact. Inaction can be at individual (when a person does nothing about preventing the spread of HIV and AIDS), family, community (communities include churches, schools and institutions, hospitals, etc.), national (those in positions of power and authority) and international level.
Mis-action	It means taking inappropriate measures as a response to the HIV and AIDS pandemic resulting in serious negative consequences. Mis-action can include the following: Prescribing only prayer, fasting, and other religious practices for PLWH and stopping them from ART, seeking for an HIV cure from herbalists and faith healers, unintentionally treating PLWH in a way that causes them pain, etc.

Discussion Question

Suggest ways through which you can eliminate HIV and AIDS related SSDDIM from Your life as an individual, Your family, and Your community

Day Five: The role of the church in multiplying SAVE and Reducing SSDDIM

The church is a community of Christ's believers who exist to be part of Jesus Christ's mission of offering good news to those in need, liberating the oppressed, healing the sick and extending abundant life to all creation. Its role in HIV and AIDS prevention is to;

Accompany and heal

To offer effective accompaniment, the church needs to refrain from judging PLWH, those affected and those highly vulnerable but rather empathize with them and focus on compassionate care for them. The church should meet such people's needs in every possible and non-stigmatizing way. It should open its doors to the marginalized and make its environment conducive for such people to experience the life affirming and life giving love of Christ. Its approach to such people should be characterized by sincerity, deep respect and willingness to learn from them, partner and work together to find common solutions. To offer healing, churches should create safe spaces for people to disclose and have meaningful conversations on HIV and AIDS related issues in ways that promote physical, psychological and spiritual wellbeing of people. This can be achieved through contextual bible studies, fellowships and other prayer gatherings where scriptures are read and interpreted in a life affirming manner within the context of HIV and AIDS and in a way that challenges the negative attitudes, speeches and conducts surrounding HIV and AIDS.

Educate and transform

Wherever it exists, the church is commissioned to teach and positively transform people for better and healthier interpersonal relationships with one another and with God. It is therefore its role to offer accurate knowledge and information about what HIV and AIDS is and what it is not, its transmission, prevention and treatment without bias. It has to create awareness through advocacy that promotes SAVE and breaks down SSDDIM among all populations. It is tasked to intensify advocacy for ecumenical and denominational initiatives against violations of the human rights of all affected populations. Through sermons, seminars, community outreach programs, and other activities, it has to teach people how best they can address the societal and structural issues that challenge SAVE or propagate SSDDIM such as gender stereotypes, imbalanced gender relations, violence, poverty, corruption, limited access to comprehensive HIV services, etc. It should call and lead people to repent out of their HIV and AIDS related

SSDDIM and lead pro-SAVE life styles. It has to keep up to date with the new discoveries and knowledge in the HIV and AIDS sector so that it is well positioned to offer relevant education at all times.

Initiate, support and implement interventions

The church should come up with practical and feasible programs to contribute towards halting the spread of HIV and AIDS. These can be anti-SSDDIM advocacy or activism campaigns, HIV testing prevention and treatment programs and empowerment programs. The church should also support such intervention by mobilizing for the necessary resources and owning their implementation. Plans and activities to multiply SAVE and reduce SSDDIM at individual, family and community levels should be integrated within the church's annual budgets and schedules rather than handling them as standalone activities.

Discussion Question

a) *Identify the available resources for your church to fulfill its role in HIV and AIDS prevention.*
b) *How do you intend to help your church utilize these resources to multiply SAVE and SSDDIM?*

UNIT EIGHT:
GENDER DYNAMICS AND HIV

Unit: Description

This course discusses the place of gender in the transmission, response to and management of HIV. It looks at how HIV affects men and women differently. It goes on to look at how the church views issues of gender and how it can use its key resources such as biblical teachings to address gender issues that make men and women being affected differently by HIV.

Unit Purpose

The purpose of this course is to make learners appreciate that gender, especially gender inequalities, results in women and men being affected differently by HIV. Noting that generally women experience gender inequalities, the course aims to make learners be champions and advocates of gender justice if we are to conquer HIV. The course looks at how the church both promotes gender inequality and can also be a champion for gender justice.

Unit Objectives

By the end of this course, learners should be able to:

1. Define gender.
2. Explain how gender is constructed.
3. Outline how gender affects men and women in contexts of HIV.
4. Analyse the role of the church in fighting for gender justice.
5. Advocate for gender justice for positive HIV response.

Unit Outline

- Day 1: Definition of Gender
- Day 2: Gender and HIV
- Day 3: The Bible and gender inequality
- Day 4: Bible, gender inequality and HIV
- Day 5: Using the Bible for gender equity in contexts of HIV
- References (at the end of the study guide)

Day One: Definition of Gender

You have completed several forms where you need to indicate your gender. Where you are to tick, the usual responses are male or female. Sometimes, in these forms, the word 'gender' is replaced by 'sex'. There is therefore a close relationship between sex and gender. The two words, however, do not mean the same thing. Sex generally refers to the biological make up of a human being. On the basis of sex, human beings are divided into men and women because of their biological differences. Thus, one's sex is therefore God given. Gender on the other hand goes beyond sexual differences between men and women. Before we try to define gender

below, consult a few dictionaries and online search engines to find out how they define it.

If you have consulted different sources as directed above, you should have established the following about gender:

- Gender is **socially constructed** when different societies define different roles for men and women. *List down the different roles assigned to men and women by your society.* Society also constructs gender by determining how men and women ought to behave and to express themselves. For example, in some societies, men are not supposed to show emotions like crying. Failure to live up to the expectations of one's gender results in one being considered less of a man or a woman.
- Since gender is socially constructed, it is **society specific**. Whereas there is a general understanding of what maleness or femaleness entails in many societies, there are peculiarities from one society to the other.
- ✓ Gender results in **categorisation of people**. Because gender defines what society expects of men and women, it also makes some gender roles more important than others. For example, society may define the roles of women as more important than roles of men or vice-versa. This will result in one gender being empowered over the other.
- ✓ Some people think that **limiting gender to maleness (masculinity) or femaleness (femininity) is restrictive** as there are other people who do not conform to the gender assigned to them. These are, for example, females who may be comfortable in taking male gender attributes. Thus, gender may go beyond male and female.
- ✓ Because gender is socially constructed, it can also be **socially deconstructed**. Society may feel that the way they have been defining manhood and womanhood has not been or is no longer working for them and therefore decide to change gender roles, beliefs, values and norms. You may have observed that certain gender stereotypes that were normal in traditional society are no longer the same in contemporary society. For example, not many societies today still hold to the view that it is not necessary to send girl children to school because they will be married. That gender belief has been deconstructed.
- ✓ Lastly, because gender is socially constructed and can be socially deconstructed, it means it can be **socially reconstructed**. Societies can begin promoting gender roles, behaviours, values and norms that they consider important for them.

From the points raised above, it can be noted that gender defines a person's behaviour, his/her role in society and the social opportunities available to him or her. It empowers or disempowers individuals. UNAIDS (1998:3) thus defines gender as, "What it means to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships." It is the

definition we will work with this week as we try to find out how gender influences the effects and management of HIV.

Discussion Question
How has the church helped in constructing the gender that prevails in your society?

Day Two: Gender and HIV

Yesterday we discussed the meaning of gender. Now that you have some understanding of gender, today we want to look at how gender impacts on HIV responses. We are all aware of the transmission and effects of HIV. Although there has been significant progress made over the years in effectively managing HIV (through prevention, care and treatment strategies), the pandemic still remains a big challenge in our societies. It is therefore important for us to continue looking at certain factors that contribute either positively or negatively to HIV responses. Gender is one such important factor. Today, we are going to look at how gender affects HIV prevention, care for the infected and affected and treatment of the infected.

Gender and HIV prevention

Besides differences in their physiological make up, there are a number of gender factors that affect men and women in their attempts to prevent contracting HIV. I will discuss a few just as examples and you can discuss more in your groups or as a class. Togarasei (2015) discusses various factors driven by prevailing masculinities that expose men to HIV. He identifies virility as one common expression of masculinity that results in men having multiple partners that expose them to contracting HIV. Gender stereotypes also expose women to HIV. In a number of societies, women are not expected to play an active role when it comes to sex. They are not expected to initiate sex, for example, or to openly talk about it. This results in them not having the powers to suggest the use of condoms, for example.

Gender and care for those infected and affected by HIV

Gender expectations also expose women and men differently to HIV. In the majority of cases, care for the terminally ill is work that is left to women. Besides exposing them to contracting HIV during the provision of care, women also unnecessarily bear the burden of care which should be shared with men. Often orphans left by those killed by HIV are the responsibility of some women relatives. Many of the child-headed families are headed by girl children who then lose the opportunity to go to school, often fall prey to sugar-daddy culture and or early marriages that further expose them to HIV.

Gender and HIV Treatment

Gender dynamics also affect HIV treatment. Studies have shown that women enrol into HIV treatment more than men. In 2017, 65% of women living with HIV had access to treatment compared with just 53% of HIV-positive men (http://aidsinfo.unaids.org/). However, despite enrolling for treatment more than men, gender dynamics such as gender-based-violence results in some women failing to adhere to treatment. Some women also fail to take the treatment appropriately because of inadequate education, especially in societies where girl child education is considered unnecessary.

Discussion Question

We have made a general discussion of how gender influences responses to HIV above, showing how it affects both men and women. However, in the majority of cases women have been found to be at the receiving end of gender inequalities. Discuss some of the gender inequalities in your society that result in men and women being affected differently by HIV.

Day Three: The Bible and gender inequality

Yesterday we discussed how gender affects HIV responses. Our discussion of gender on day 1 presented that the way gender roles, beliefs, values and norms are formulated result in some people being disempowered. In the majority of cases women are disempowered by gender norms prevailing in their societies. I hope your discussion yesterday highlighted this. Gender inequality seriously affects women in contexts of HIV. Today we will focus on how some biblical texts promote gender inequality and especially gender-based violence that exposes women to HIV. There are many such texts in the Bible but because of time we shall only look at a selected few.

Texts that promote the inequality of women

Genesis 2:20-25

We begin right at the creation. Although the first creation story presents God as creating both men and women at the same time (Gen. 1:26-27), Jewish and Christian traditions have chosen to highlight the second creation story (Gen. 2:20-21) that presents a woman as having been created after man as a helpmate when God noticed the loneliness of the man. In this story, the woman is not at the centre of God's plan of creation as she is only created from the rib to address the man's loneliness. Following this line of interpretation, women are therefore considered to be of low status compared to men both biologically and socially. As Mary J. Evans (1983:14) observes quite candidly, this text teaches the subordination of the woman in four ways: her

creation after man, her creation from the man, her being named by the man and her description as a helper. No wonder, the same tradition continues to interpret the 'fall of humanity' in Gen. 3 as a result of a woman, Eve, who gave in to the tricks of the serpent. With this fall, the tradition goes, came male domination, death and pain in the world.

2 Sam. 11

Bathsheba is portrayed as the object of sexual desire and aggression. This is how some men involved in gender-based violence (GBV) view the bodies of women. The story echoes sound that we are quite familiar with: men's abuse of power and privilege to violate women at work places, in schools, in church and such other institutions where men use their power to abuse women sexually. Exum (1996:21) explains the violence in this text

> *....only five actions- three on David's part and two on Bathsheba's part are minimally described. He sends, he took and he lay: the verbs signify control and acquisition. In contrast, only her movement is described: she came and she returned.*

Thus, Exum is correct that the narrative is set in a context of aggression and violence. A man reading such a story by a man who was beloved by God (2 Sam. 7:16ff) would surely feel nothing wrong with behaving in the same manner that David did.

Texts that promote violence against women

1 Sam. 13:1-22

The story recounts the sexual abuse of a young woman by a person she trusts, her own brother. This is a story that sounds many bells in the memories of many in sub-Saharan Africa. Cases of girl child sexual abuse by known close family members abound in our societies. For want of protecting the 'name' of the family, many such perpetrators are not reported or if reported, the cases are later withdrawn by family members

Judg. 5:30, Lam. 5:11, Amos 4:2-3, 7:17

The rape and humiliation of captive women is taken for granted. In the case of wars, married women are the major victims of death while unmarried ones are forced to marry the murderers of their mothers and sisters. Thus, besides the rape of Tamar that we discussed under texts of terror above, there are several other texts on the wanton raping of women often as men strive to demonstrate their powers. The rape of Dinah (Gen. 34), and of David's ten wives (1 Sam. 16:21-22), the abduction of the dancers of Shiloh (Judg. 21:19-23), are examples.

Discussion Question

How can you explain these texts to a youth member of your church who questions a Bible that promotes gender inequality?

Day Four: Bible, gender inequality and HIV

Yesterday we looked at how some biblical texts present women in a way that promotes their inferiority, gender inequality and sometimes gender-based violence. Today we want to look at how all this affects HIV response. I shall give a few explanations and leave the rest to you to discuss as a class. You can take each of the texts we have discussed, or you can decide to discuss them in general.

The Bible is a very influential book in Christian beliefs and practices. Churches that tend to read it literally, do not accord women their equal status. When women are not accorded equal status, they become prone to HIV in a number of ways:

- The view that women were created for the sake of men (as a helper) leads to the characterisation of women as passive, ignorant and therefore dependent on men and leading men to control their sexuality. When women are seen this way, they are exposed to HIV.
- Texts like 2 Sam, present men as sexual predators who go around looking for women to have sex with. This promotes multiple sexual partners. It promotes abuse of women by their superiors in workplaces, in politics and even in government. This exposes both men and women to HIV.
- Texts such as the rape of Tamar (1 Sam) that have been described by Phylis Trible (19) as, 'texts of terror', promote violence against women. In situations of violence or the threat of violence, women are severely constrained in their ability to take measures to protect themselves from infection or insist that their male partners take precautions against HIV (UNAIDS 1998).

Discussion Question

Explain how gender inequality as presented in some biblical texts promote the spread of HIV.

Day Five: Using the Bible for gender equity in contexts of HIV

As we end this week of discussing how gender affects HIV response, we must reflect on how best we can use the Bible positively in the context of HIV. The Bible remains the major resource of the Church. It is the role of church leaders then to always reflect on the way they interpret the Bible in order to build communities of God. The texts that seem to disempower women have already received different treatment by different people. Let me briefly share with you how some people have treated these texts:

- Radical feminist scholars like Mary Daly (1985) suggested that women should refuse

to read the Old Testament or even the whole Bible as it is a patriarchal text that undermines women. Mary Daly argued that there is no freedom for women in the whole Judeo-Christian tradition. With her declaration, "If God is male, then the male is God," Daly problematized patriarchy which she described as a creation by men to serve the interests of men. For this reason, she believed women cannot get liberation from the Bible.

- Other feminist scholars called soft feminists were against rejecting the biblical texts, but instead sought positive roles of women in the Bible to identify with. Scholars like Mary Evans (1983) take this approach. They focus on positive roles of women like Sarah, the mother of nations and Deborah, who became a judge.
- Some scholars who want to continue with the tradition of valuing the biblical texts as the Word of God consider the biblical texts that undermines women as teaching today's Christian men what not to do. For L. Ewusha (2012) the texts show the effects of sin following the fall in Genesis 3. Before the fall Adam represented caring and responsible manhood, "This is now bone of my bones, and flesh of my flesh…" (Gen 2:23-24). He says it was only after the fall that the husband, in response to God's punishment, was to rule over his wife.

What we learn from the above is that we should avoid reading and interpreting the Bible in a way that put one gender at the risk of HIV. As Christians and Christian leaders, we must always be cognisant of the fact that biblical texts are active stories with a bearing on our contemporary societies. Our reading and interpretation should therefore promote life and life in abundance (John 10:10). We should pay particular attention to the needs of women, who have generally been disadvantage by our gender norms. Guided by what is of interest to women and girls, the re-reading should therefore be unapologetically interested. Accepting its subjectivity, the re-reading should declare its interest from the onset. Our interpretive interests should be, among others, to save and promote life, to seek justice for all and to promote love and peaceful co-existence of all human beings including the whole of the created order. This is what we find in Our Lord and Saviour, Jesus Christ, who demonstrated gender justice despite living in a world like ours where women experienced gender inequality.

A few examples on how Jesus promoted gender justice and equality is highlighted below:

- In a world where women could not be disciples, Jesus accepted many female disciples (8:1-3) allowing them to leave their homes and following him. He even praised those who abandoned domestic chores to take their places among male followers (Luke 10:38-42).
- Jesus forgave a woman who was a sinner (7:36-50) allowing her to touch and

kiss him. He also allowed a haemorrhaging woman to touch him (8:43-48).

- Against cultural taboos that forbade men from speaking to women in public, Jesus spoke publicly with the Samaritan woman (John 4), the widow of Nain (7:12-13), with the haemorrhaging woman (7:48) and with a woman who called him from the crowd (11:27-28).

From these stories we can learn that Jesus saw men and women as equal before God and therefore was against gender beliefs that disempowered women. As H. Flender summarises, this means, "that man and woman stand together and side by side before God. They are equal in honor and grace; they are endowed with the same gifts and have the same responsibilities.

"Discussion Question
Respond to Mary Daly's view that, "If God is male, then the male is God."

UNIT NINE:
HIV AND FAITH HEALING: INTERACTING WITH PEOPLE LIVING WITH HIV, EMPHASIS ON HIV TREATMENT AND ADHERENCE

Unit Description

This course seeks to equip students with tools for effectively journeying with people living with HIV. It emphasizes on the importance of combining faith with seeking medical treatment for HIV. The course also offers suggestions on how religious leaders can offer critical solidarity and compassionate care for people living with HIV whilst ensuring that they adhere to medical treatment. It also foregrounds the importance of religious leaders in challenging stigma and discrimination in the context of HIV and AIDS especially in sub-Saharan Africa.

Unit Purpose

The main purpose of this course is to demystify the purported dichotomy between antiretroviral therapy and faith healing. It highlights the pivotal role that religious leaders are capable of playing in encouraging people of faith to embrace antiretroviral therapy as God's healing balm. The course also explicates how religious leaders are strategically positioned to promote voluntary HIV testing, comprehensive treatment uptake and adherence to antiretroviral therapy.

Unit Objectives

At the end of the course, learners will increase the knowledge and skills that will enable them to:

1. Articulate the interface and complementarity between faith healing and medical treatment in the context of HIV and AIDS in Africa.
2. Assist faith communities to appreciate the fact that faith healing and antiretroviral therapy are not antagonistic to each other.
3. Encourage faith communities to voluntarily undertake an HIV test.
4. Promote comprehensive treatment uptake and adherence to antiretroviral therapy.
5. Offer counselling, compassionate care, spiritual support and solidarity to members of their faith communities undertaking antiretroviral therapy.
6. Creatively challenge stigma and discrimination targeted against affected and infected members in their faith communities.
7. Promote and uphold the basic rights of people living with HIV.
8. Critique problematic theological pronouncements and challenge harmful approaches to faith healing.
9. Develop life-giving theologies that promote adherence to antiretroviral therapy.
10. Address the specific needs of children, orphans, the elderly and people with disabilities who are either infected or affected by HIV.

Unit Outline

- Day one: Introduction: the quest for holistic healing and well-being in the context of HIV & aids in African faith communities
- Day Two: HIV competent churches: church leaders taking the lead to ensure universal access to antiretroviral therapy
- Day Three: interrogating problematic theological pronouncements and harmful approaches to faith healing
- Day Four: Churches becoming centres of excellence in promoting universal access to ARVS and adherence to treatment
- Day Five: Accompaniment and solidarity: churches as safe havens for addressing silence, stigma, denial and discrimination
- Conclusion

Day one: Introduction: The Quest for Holistic Healing and Well-Being in the context of HIV & AIDS in African Faith Communities

> *At the center of both anti-retroviral treatment and faith healing is the quest for health and well-being. This is a major preoccupation in all the religions of the world. Moreover, human beings all over the world seek health and well-being. It is not a uniquely African phenomenon. Healing has been an integral part of humanity's religious quest* (Chitando and Klagba 2013:5).

The World Health Organization (WHO) defines health as "a complete state of physical, mental, spiritual and social well-being and not merely an absence of disease or infirmity." Hence, the term "healing" refers to the process of restoring health in every area of life: mental, physical, emotional, social, spiritual and structural. Holistic health, healing and well-being are the central concerns for most African people. With at least two thirds of the global population of adults and over 90% of the children living with HIV, Sub-Saharan Africa has been hardest hit. One in every ten people is living with HIV in some African countries. HIV is also the leading cause of death in Africa. Hence, the HIV epidemic has raised major concerns and feelings of insecurity within our faith communities. Religious leaders play a pivotal role in securing the health and well-being of their communities.

> But healing is a hot topic: What exactly do the churches mean by healing? Can healing always occur? Can healing occur without physical cure? Are the claims sustainable or fraudulent? Some churches emphasize divine healing without any resort to modern medical facilities. Others perceive them as being complementary. It is surmised that the popularity of divine healing in Africa arises from the poverty in the communities that are plagued by the collapse of the health care delivery system (Kalu 2008: 263).

The foregoing citation underscores the ongoing tension between adherence to anti-retroviral treatment and faith healing confronting people of faith in sub-Saharan Africa as individuals and families grapple with HIV. The ambivalence with which HIV testing and antiretroviral therapy are perceived in some circles of our African faith communities necessitates the intervention and advocacy of religious leaders to positively influence a change of such mind-sets. Countless people do not seek or access treatment because of:

- lack of information,
- fear
- lack of awareness about their status

It is essential for people to know their HIV status in order to access treatment. However, for them to feel free to seek for testing, stigma and discrimination must be reduced and eventually eradicated. Church leaders are strategically positioned to minister to people from all walks of life and to help communities to overcome silence, denial and fear.

> Health, healing, and wholeness of life are gifts that we as people of faith can offer others and ourselves when we are fully open to learning from and with each other (Gunda et.al. 2019: v).

Discussion Question
With particular reference to your community of faith, identify the main reasons why people are afraid to go for HIV testing?

Day Two: HIV Competent Churches: Church leaders taking the lead to ensure Universal Access to Anti-retroviral Therapy (ART)

> **AN HIV COMPETENT CHURCH** is a church that has first developed an *inner competence* through internalization of the risks, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassionately. In order to progress to outer competence, there is need for *leadership, knowledge and resources. Outer competence* involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of the infected and affected, mitigates the impact of HIV and ultimately restores hope and dignity (Parry 2008:20)

It is imperative for church leaders to place themselves at the centre of the HIV response in Africa. By providing the much-needed leadership, they will make a whole world of difference in promoting health and saving lives. As noted by Dube (2003); Chitando (2007a) and Parry (2008), the church should be transformed into a safe space where members feel comfortable to talk about their HIV status in the confidence that they will receive the support that they deserve. This calls for the church to become healing communities and above all, they should be "HIV competent." When the church in Africa becomes fully HIV competent, the effects of the epidemic will be significantly reduced.

> Church leaders are essential to changing attitudes, behaviour and practices that promote the negative trends of HIV and AIDS in Africa. Church leaders are opinion leaders in the majority of Christian communities. People are receptive to their leadership and this provides the opportunity for pastors and minister to influence perceptions and encourage people to get tested and therefore have the possibility to access treatment (Ecumenical Pharmaceutical Network (EPN), 2009: x)

Church leaders are key to making this happen. They can achieve this by:

- Playing a key role in influencing policy to ensure that there is universal access to prevention, treatment and care and support
- Serving as active frontline advocates for affordable, available, safe and effective antiretroviral drugs - including those for children

> The Church is regarded as a highly reliable social institution in Africa. Its pronouncements on various ethical issues are taken seriously…The dependability of the church in Africa puts it in a strategic position to tackle HIV and AIDS. The leadership of the church can make use of the pulpit to disseminate information relating to HIV and AIDS prevention and care. They can also increase the knowledge of treatment among their members by providing the latest information regarding antiretroviral drugs. Their messages will be well received, as the audience already considers them as representatives of a credible institution (Chitando, 2007a:15).

Discussion Questions

Identify the main characteristics of an "HIV Competent" Church

Day Three: Interrogating Problematic Theological Pronouncements and Harmful Approaches to Faith Healing

> Theologians and the church leadership would do well to speak out boldly providing clear direction not just to congregations but also to fellow clergy so that the church can have a Christ centred approach to faith healing that benefits all people (EPN, 2009: xi).

In journeying together with people living with HIV, church leaders need to clearly articulate the difference between being healed and being cured.

> Healing is a natural process, it is attributed to faith and is within the power of everyone. Curing and managing disease is what doctors are called upon to do. This usually consists of an external treatment; medication or surgery is used to mask or eliminate symptoms. In the case of HIV, medication is not a complete cure, but it is a way to eliminate symptoms, prolong life, increase quality of life, and eliminate the chance of transmitting HIV to sexual partners…Healing goes deeper than curing and comes from within. It addresses the imbalance that underlies the symptoms. Healing brings together the often-hidden aspects of a person's life as they relate to their illness. Healing is different from curing, though curing and the restoration of physical function may accompany healing (Gunda et.al. 2019: 28).

There is an urgent need for some churches in Africa to crawl out of their shells of theological rigidity which dichotomize faith healing and medical treatment. Such a rigid stance leaves members in a quagmire especially when they are being made to choose between the two.

> It is against the background of the popularity of healing in AICs [African Independent/Indigenous Churches] that some prophets have claimed to have the power to heal their clients of HIV and AIDS. In their theology, the Holy Spirit defeats all illnesses. They prescribe prayers, use of oil, holy water and other agents to effect healing. In their scheme, HIV is defeated in the same way that all other negative forces are defeated (Chitando and Klagba 2013:13).

Church leaders must climb down from their ivory towers and revisit their theologies so that they and their members can comfortably talk about ARVs as life-saving and life enhancing medication which is God's gift for humanity. The church's healing ministries should not in any way compete with nor jeopardize the medical interventions, neither should medical treatment claim exclusive truth. Instead, the two should complement each other in order to bring about holistic healing.

> There is a broad consensus that biomedical treatment is perfectly compatible with Christian notions of the sanctity of life, and that ART should not be seen as competing with but as manifesting God's power, and that ART should be included in theologies of healing. Such views are remarkably echoed in the way ART is interpreted in Islamic theology. In Islam as well, technical innovation is viewed as originating from God (Burchardt, Hardon & de Klerk 2009: 10).

Theological institutions must cultivate relevant biblical hermeneutics in the time of HIV. The HIV epidemic beckons us to read and interpret the bible in a new and creative way. Such reading of the bible should help us to proactively deal with the epidemic and save lives.

> Some people interpret the Bible, especially the New Testament, as teaching belief in, and practice of, faith healing. There have been claims that faith can cure blindness, deafness, cancer, HIV and AIDS, developmental disorders, anaemia, arthritis, corns, defective speech, multiple sclerosis, skin rashes, paralysis, and various injuries. These claims rightly point to claims of "faith curing" (Gunda et.al. 2019: 29).

Whilst it is important to have faith and to pray for healing, the accompaniment offered to the HIV infected by church leaders should not hinder people from accessing ART. Rather, church leaders should encourage people to embrace ART and to continue praying and believing that God's healing power is behind the invention of ARVs. The availability of ARVs should therefore be envisaged as God's healing grace.

> Faith healing entails the ability of faith to help restore balance to human beings by addressing psychological, biological, social, economic and spiritual issues that bring about the lack of such balance. Faith healing is holistic and compliments treatments prescribed by medical and psychiatric professionals (Gunda et.al. 2019: 29).

Instead of faith healing and medical healing being antagonistic to each other, their collaboration and complementarity would alleviate undue suffering for people of faith who are living with HIV.

> The theme of healing once again challenges the church in Africa to demonstrate *theological maturity* and *realism*. On the one hand, the temptation is high for those whose worldview no longer leaves room for miracles to refuse to dialogue with those who are still open to such a possibility. On the other hand, those who champion miracles might wish to condemn those who raise critical questions as lacking in faith. We are convinced that both sides need to come to the conversation table and contribute to health and healing in the time of HIV (Chitando and Klagba 2013:27).

Discussion Questions

1. What do you understand by the following terms?

(a) Healing (b) Curing (c) Faith healing

Day Four: Churches becoming centres of excellence in promoting universal access to ARVS and adherence to treatment

> Adherence is defined as the extent to which a patient's behaviour coincides with the prescribed health-care regimen as agreed upon through a shared decision-making process between patients and the healthcare provider. This includes taking them at the right time and in the right amount (WHO).

There is overwhelming evidence that ARVs improve the quality of life of people living with HIV. Church leaders should therefore tap into the efficacy of ARVs by resolutely assisting people to access this life transforming and life sustaining treatment, particularly as there is widespread fear, misunderstanding, and stigma surrounding HIV and ARVs. The church leaders should demystify the negative and falsified myths surrounding ARVs. HIV should challenge church communities to come out of their shells and engage in discussions about sexuality, condom use, HIV testing, ARVs and most importantly adhering to treatment.

> Religious leaders are strategically placed to promote adherence (following through on the use of medication as suggested by a treating doctor) to antiretroviral therapy and to challenge stigma and discrimination (Gunda et.al. 2019: vi)

The churches' health messages should also emphasize on availing accurate information about ARVs. Ignorance is one of the major impediments in effective HIV treatment and care. As stated in Hosea 6: 6 "My people are destroyed for lack of knowledge." It is therefore pertinent for churches to become oasis of knowledge regarding the proper medical approaches for managing the HIV epidemic. Some church leaders have been notorious for misleading people with claims of having exclusive spiritual healing powers to the detriment of all efforts being made by the medical fraternity.

> Some pastors have been discouraging their members and clients from adhering to anti-retroviral treatment, claiming that they can effect miraculous healing "in the name of Jesus." This has left many Christians living with HIV in a dilemma. On the one hand, they are being encouraged to ensure that they take their medication on time. On the other hand, some of their spiritual leaders are encouraging them to abandon this treatment altogether. In many ways, it is a replay of the old debate between "science" and "faith." In the face of HIV in Africa, however, whether or not to take anti-retroviral treatment has life-and-death implications (Chitando and Klagba 2013:2).

Instead of demonizing and denigrating ARVs, church leaders should devise ways of assuring people that the use of medical interventions is not in any way a sign of lacking faith in the divine healing power.

> While ART (anti-retroviral treatment) has undeniably saved and improved the lives of millions of people, it has also introduced new challenges that need to be addressed to safeguard sustained treatment success. (Burchardt, Hardon & de Klerk 2009: ix)

Church leaders can positively contribute towards effective adherence to treatment by ensuring that:

- People who have access to ARVs have been empowered and helped to share their experiences freely so that others may benefit
- The stigma faced by people enrolled for ART has been eradicated
- Those who already take ARVs need support so that they can maintain their treatment regimen
- Those who don't need to take ARVs also need to understand them in order to support those that do need them (EPN, 2009: 17).

> All our responses must be firmly rooted in the realities experienced by the most affected and a visible reflection of their expressed needs. Involvement and meaningful collaboration with the same people, and other key stakeholder brings authenticity to our decisions and our actions. What should make our responses different from those of the secular society are our deep-rooted spiritual values that arise from our faith in Jesus Christ. It is our responsibility and privilege to accompany those who suffer, to bring comfort and relief wherever possible, to stand together in the hour of need, to be the voice of the voiceless and above all, to restore hope, which is the essence of living. These values cannot be reflected adequately in our activities if we fail to be solidly grounded before seeking to tackle HIV in a programmatic way (Parry, 2008:21).

Discussion Questions

With specific reference to your context, discuss the reasons that negatively impact on people's adherence to ARVs

Day Five: Accompaniment and Solidarity; Churches as Safe Havens for Addressing Silence, Stigma, Denial and Discrimination

> Accompaniment means walking together with someone or with others in solidarity. Their journey becomes our journey also. Through accompaniment, we become willing companions. People experiencing the effects of HIV and AIDS are on a journey, and faith communities are invited to accompany them in this journey (Acts 16:1-40). As believers, we believe that God accompanies us wherever we go and in whatever we do. And since God wants us to imitate God always, we believe that God also wants us to accompany others on their journeys. This is especially true if they are journeys of life and death, journeys that would be scary when undertaken in isolation (Jer. 1:7-8) (Gunda et. al 2019:40).

A faithful, intimate presence in the lives of those with HIV and AIDS, witnessing to them of Jesus' healing touch, is one of the most important responsibilities of all people of faith. In essence, church leaders should offer accompaniment to members who are either infected or affected by HIV.

> The church's credibility in Africa is due to its many pro-poor programmes. When it proclaims messages that affect the lives of people, the community takes notice. The church should therefore capitalize on its credibility in the context of HIV and AIDS. When the church takes a life-affirming stance on HIV and AIDS prevention, treatment and care, communities can be galvanized into action (Chitando 2007a:15).

- It is the responsibility of all people of faith to educate themselves so as to effectively educate others. Jesus said, "The Truth shall set you free," (John 8:32), yet too often, people deny the truth, or avoid learning about HIV and AIDS because of fear.
- Following Jesus example, people of faith are called to eat with people living with HIV and to share their home with them (Matthew 25:6); to touch them and show them love and care (Matthew 8:2–4); and to heal people with HIV and AIDS (Luke 17:11–19).
- Our Lord and Saviour Jesus Christ came that we all may have life and have it abundantly (John 10:10). It is therefore only logical that the ministers of the church take up the challenges that HIV presents to our generation by emulating Jesus Christ through the practice of true inclusive ministry: preaching the gospel and healing the sick.

> HIV/AIDS thrives through all forms of social injustice that often leaves people powerless to implement decisions that empower them against the epidemic. HIV/AIDS is therefore very much a social justice issue, one that pushes us as a world to seek justice for ourselves, for and with all members of the earth community and in all our relationships, institutions, and structures (Dube 2004:5).

- The HIV pandemic is not only a personal, family, and national tragedy, but also a faith concern.
- Church members, ministers, and leaders cannot afford to look the other way or "pass by on the other side" as did the Priest and the Levite on the Jericho Road. Like the good Samaritan, HIV continues to challenge us all the time to find new answers and to make possible Jesus' instruction to "go and do the same" (Lk 10:36-37).
- The Church needs to exude compassionate care so as to transform the lives of the infected and affected members in our midst (Bate and Munro, 2014)
- The Church has resources, capacity, and the moral authority to intervene. The ultimate test of the Church is the spiritual maturity of its people and its leadership. Nowhere is this maturity more tried than in the way the Church responds to the needs of suffering communities (EPN, 2009: 18).

African churches need *friendly feet* to journey with individuals and communities living with HIV and AIDS, *warm hearts* to demonstrate compassion and *anointed hands* to effect healing. African churches are also called upon to train their voices so that they can speak out and challenge systems of oppression. AIDS competent churches work towards the transformation of death-dealing practices while strengthening life-affirming ones (Chitando 2007b:1).

Discussion Question
Explain the meanings of the terms "Accompaniment" and Solidarity in the context of HIV and AIDS within your context

Conclusion
The HIV epidemic has presented a *kairos* moment not only to the African churches but to the global community. If churches are to fulfil their goal as healing communities, they need to seriously provide leadership in treatment literacy, HIV testing and more importantly to accompany those of us who are either infected or affected. By providing accurate information that addresses myths and misconceptions about ARVs, church leaders will be positively and effectively contributing towards treatment uptake and adherence. Leaders can also lead the way by publicly going for a test themselves and showing understanding and compassion for those who are already living with HIV. They should also work towards insulating their churches and their communities from the stigma and discrimination associated with HIV.

Exclusive claims of faith healing in the context of HIV and AIDS in sub- Saharan Africa are deterring people living with HIV from taking medication as prescribed by their doctor (EPN 2009: 98).

UNIT TEN:
INTRODUCTION TO DISASTER AND RISK MANAGEMENT FOR RELIGIOUS LEADERS

Unit Description

This course examines the reality of disasters in faith communities as well as the importance of being prepared when disaster strikes. The course explores the different types of disasters that threaten communities. Further, the course also explores the different strategies of reducing the risk that communities face from these disasters. The course helps to illustrate how disaster preparedness is a critical component of the mission of the church.

Unit Purpose

The purpose of this course is to introduce the students to the basics of disaster and risk management. While Religious Leaders are always considered important during and after disasters, as spiritual and emotional mentors; this course sees RLs as critical leadership in all communities before, during and after disasters and such leaders must be equipped with the requisite skills. This course seeks to equip RLs with the necessary information and skills to provide leadership before, during and after disasters.

Unit Objectives

At the end of the course you will be able to:

1. Define disaster and risk.
2. Outline the disaster and risk management cycle.
3. Understand the specific needs of the different stages in the DRM cycle.
4. Appropriate biblical texts in leading communities before, during and after disasters.
5. Understand the theological rationale for disaster preparedness.

Unit Outline

- Day One: Disaster and Risk: Definitions
- Day Two: The Disaster and Risk Management Cycle
- Day Three: The Needs - pre, during and post-Disasters
- Day Four: Contextual Bible Study and Disaster Preparedness
- Day Five: Theology of Preparedness
- References (at the end of the study guide)

Day One: Disaster and Risk Definitions

Today we begin a week of learning about disaster preparedness as faith communities and faith leaders. Our focus today is on understanding key terms that we must know as we seek to

understand disasters and how we ought to respond to disasters as faith communities.

- ✓ A **disaster** is *"a serious disruption of the functioning of a society, causing widespread human, material or environmental losses which exceed the ability of the affected society to cope using only its own resources."* There are different types of disasters but widely divided into two **natural disasters** and **man-made disasters**.
- ✓ **Natural disasters** are caused by natural **phenomena** without the direct influence of human beings, such as *earthquakes, landslides, tsunamis, volcanoes, floods, drought, wildfires, heat waves, cyclones and storms, disease epidemics and pandemics*.
- ✓ **Man-made** disasters are caused by human beings and mostly occur in or close to human settlements. Among the many man-made disasters are *conflicts (wars), displaced populations, industrial accidents, transport accidents, environmental degradation, pollution, some epidemics (cholera, typhoid), some "natural disasters" like landslides, erosion, siltation* can also be traced back to human activities).
- ✓ **Disaster risk** is expressed as the likelihood of loss of life, injury or destruction and damage from a **disaster** in a given period of time. If we live in an area that is prone to flooding, the risk is higher if we are in the rain season.
- ✓ **Mitigation** refers to the strategies or interventions implemented before a disaster strikes or in response to the onset of a disaster event to minimize its impact or to prevent ultimate catastrophe. What can we do to reduce our risk if disaster strikes?
- ✓ **Preparedness** refers to measures taken to prepare for and reduce the effects of **disasters**. That is, to predict and, where possible, prevent **disasters**, mitigate their impact on vulnerable populations, and respond to and effectively cope with their consequences. Preparedness is mostly associated with the period when a disaster is now almost certain to happen but before it actually strikes, what can we do to reduce its impact in our community?
- ✓ **Vulnerability** refers to the characteristics and circumstances of a community, system that make it susceptible to the damaging effects of a hazard. Where we have a greater risk of being exposed to a disaster, we are categorized as "vulnerable" – some are more vulnerable than others depending on their closeness to the disaster and its impact. Although every person is to some extent vulnerable to disaster, in most instances there are certain categories of persons who tend to be more vulnerable than others.
- ✓ A **hazard** is a dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage. A hazard can also be used interchangeably with disaster.

Every community is susceptible to some disasters but not to all disasters. It is important for us to understand and to know what type of disaster is most likely to happen in our community.

Once we know our risk to particular disasters, then we must come together as a community to mitigate and prepare as well as learning how to respond and recover in the event that the disaster eventually strikes.

The words we have learnt today are important because we will hear them often or we will use them often, as well, if there is a disaster in our community.

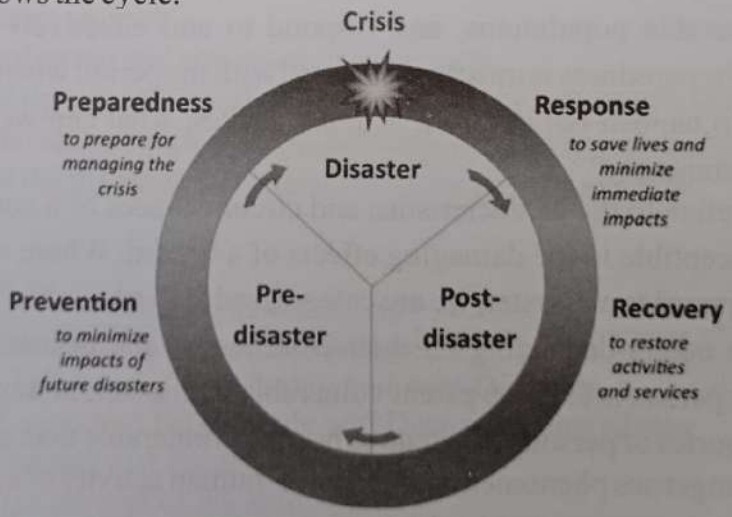
Discussion Question
What is a disaster and what are the two main types of disasters?

Day Two: The Disaster and Risk Management Cycle

Yesterday we learnt several words that are important in understanding disasters and how to manage disasters when they occur. Today, we want to look at how we must act as a community to deal with disasters.

Most disasters give us warning signs that they will come but there are some that will catch us by surprise. Since most disasters give warning signs, we can always try to stop the disasters from happening or to reduce their impact when they happen.

The process of managing disasters is called the disaster and risk management cycle. The diagram below shows the cycle.



It is a cycle because these steps can be repeated over and over again because managing disasters begin before the disaster has happened, continue during the disaster and into the period after the disaster. Then we begin to prepare again for other disasters that might come in the future.

There are four steps or stages in the disaster and risk management cycle:

1. **Prevention** – Communities must take measures to reduce the risk of having particular

disasters happening in their own places. Promoting provision of safe water and good sanitation infrastructure can prevent disease outbreaks in a community. Discouraging building of houses close to water ways and in valleys will reduce or prevent the flooding and loss of lives. Take action to reduce the risk or vulnerability of the community to specific disasters.

2. **Preparedness or Mitigation** – this is especially important for those disasters that give warning signs before they strike. Cyclones, heat waves, droughts, flooding, some pandemics or epidemics give warning signs that they are coming. When the National Disaster Management Authority (NDMA) issues warnings to communities of impending disasters, communities must take measures to reduce the severity of the impact the disaster will have. Measures such as storing food and water, moving to higher ground, seeking shelter in stronger structures, securing and storing medical supplies are all important steps of mitigating or being prepared. Assigning roles and developing signals to be used by the communities are all important steps. Identify places of refuge.
3. **Response** – When disaster strikes, it is not time to contemplate or to start planning, it is time to act! When disaster strikes, lives (of human beings and livestock) are at risk and it is important to save as many lives as is possible. Activate rescue teams to search for survivors and bring them to safety, provide safe and clean water and food for survivors, provide shelter and clothing to survivors. At this point, the focus is the "here and now", provide spiritual guidance to survivors.
4. **Recovery** – Once the response phase has succeeded in saving lives and providing the immediate needs of survivors, the focus will gradually move towards recovery. How can we help survivors return to their pre-disaster lives or better? There is need to understand their economic systems in order to understand how best to help them – whether we need to help them identify new markets for their produce, whether we need to help them restock their livestock.

While Kenya has the NDMA as the nationally mandated institution to manage disasters, we know disasters do not happen in government buildings, disasters happen in communities where we, as religious leaders, live. We ought to provide leadership and be the key links between communities and government institutions and other stakeholders like NGOs. Let us know that our faith mandates us to provide leadership to our communities in times of plenitude, deprivation, disasters and disease.

Discussion Question

Why is the disaster and risk management cycle important for any community?

Day Three: Critical Disaster Publics

Yesterday we learnt the management cycle, the steps that we must take before, during and after a disaster has visited our community. Today, we want to look at the people that will be worst affected by a disaster. Who are the people that will be most affected by a disaster in your community? It is also important to know that different disasters affect different people differently.

Deuteronomyy 10: 17-18 - *For the LORD your God is God of gods and Lord of lords, the great God, mighty and awesome, who is* ***not partial*** *and* ***takes no bribe****, who* ***executes justice*** *for* ***the orphan*** *and* ***the widow****, and who loves* ***the strangers****, providing them* ***food*** *and* ***clothing****.*

❖ Our God empowers us to identify the needy and to meet their needs! That is faith-based disaster risk management! We can also reduce their risk by reforming our communities and not wait until they are already in trouble.

Who are the most vulnerable members in our communities during most disasters?

- **First responders** – The men and wom en that are the first to search for survivors and victims often end up being victims themselves because of lack of adequate information on the risks involved.
- **Children** – Children are almost always a vulnerable group because among them, are those who cannot do much for themselves. It is not surprising, therefore, that in many disasters children are among the worst affected.
- **The Elderly** – Elderly persons are those that have seen their better days, when they were stronger and more active but are now mostly dep endent on others, mainly their children and grandchildren.
- **Persons living with Disabilities and mentally challenged Persons** – Persons living with disabilities are also hugely impacted by disasters.
- **People living with and affected by terminal diseases** – Persons that are living with incurable diseases are sometimes more vulnerable in disasters than other persons.
- **Women** – Women, mothers, sisters, wives! Women carry the brunt and burden of most disasters by virtue of simply being women. Women are predisposed to care for others more than they care for themselves. This predisposition make women brave a disaster to secure their families, especially those that cannot help themselves. Women are in most disasters, the real first-responders and frontline workers, with little training, their natural instincts increases their vulnerability.

As we plan on how to reduce the risks in our communities, we must also think directly on what strategies we can use to reduce the risk of these critical disaster publics in our communities.

Going back to our biblical text above, we can be sure that the Lord would be saying to us today;

- **"In times of disasters, remember to protect the children, the elderly, persons living with disabilities, persons living with terminal health conditions and women!"**

Discussion Question
What are critical disaster publics and why do they need special care during disasters?

Day Four: Contextual Bible Study and Disaster Preparedness (Matthew 24:36-44)

Today we want to learn through studying the Bible that being prepared for disasters is demanded of us by God. We will, therefore, read Matthew 24: 36-44 but before we read this text, l***et us answer the following questions;***

- ✓ What situations in your daily life demand being prepared?
- ✓ What happens to those that are not prepared?
- ✓ What are the advantages of being prepared for the things you encounter in your life?

Now read the text and answer the following questions;

- ✓ Who are the characters in this text?
- ✓ What is the situation for which the listeners are being encouraged to be permanently in a state of preparedness?
- ✓ Why is unpreparedness not encouraged or promoted?

Having gone through the study of the text, please go ahead and answer the following questions ***on what you can do to promote disaster preparedness in your community.***

- ✓ What are the situations for which we must always be in a state of preparedness? List such situations down.
- ✓ What are the strategies for achieving a "state of preparedness" for ourselves and our communities OR how are we going to reach the level of preparedness that will make us provide leadership to our communities?
- ✓ What are we going to do to improve the state of preparedness in our communities for all possible situations that might arise?

Possible Plan of Action

Situation	Strategies	Implementation
Disease Outbreak	-Promote safe water and sanitation facilities in the community	-Use your sermons and teachings to speak about Water and Sanitation
	-Always work in partnership with health service providers in the community	-Take time to sit down with nurses and doctors and to understand how you can work with them
	-Constantly search for information and disseminate such information in the community	-Establish contact with Department of Civil Protection in your area and be informed of potential dangers
Natural Disasters (Drought, Floods, Earthquakes etc.)	-Improve farming techniques to increase yields	-work with farming experts to provide communities with relevant information and skills
	-Improve preservation techniques in order to keep food reserves	-Droughts and famine can be mitigated by an improvement in food preservation and storage techniques – how can we do that?
	-building in safe places and stronger structures	-some disasters can be mitigated by choosing appropriate places for construction of houses and the type of structures that are built. Promote safe places and strong structures!
Man-Made Disasters (Wars, transportation accidents, water and air chemical pollution, structure failures etc.)	-Speak out against the tendency to cut corners to cut costs in the community	-building inspectors must do their jobs properly, cars must be serviced
	-Everyone must become an environmental police officer – let people know how a sick environment will lead to a sick community	-protecting the environment is protecting one's own life and the lives of their children and grandchildren. Advocate for the environment
	-Know your environment and take action as soon as you see some unusual changes in your environment!	-encourage community to plant trees and avoid de cimating the environment

You can add more situations and strategies as well as implementation plans.

Discussion Question
Disaster preparedness is Christian and biblical! Give reasons why you agree or disagree with this statement.

Day Five: Theology of Preparedness

In yesterday's lesson we studied the Bible and learned from that as believers, we ought to always be ready to provide leadership and to save lives whenever the need arises. Today, we want to continue by looking again at how being prepared for disasters must always be a part of how we understand and talk about our God. Preparedness is part of our everyday God-talk!

Luke 12:35-36 - ***Be dressed for action*** *and* ***have your lamps lit****; be like those who are* ***waiting for their master*** *to return from the wedding banquet, so that* ***they may open*** *the door for him* ***as soon as he comes*** *and knocks.*

Faith communities are action communities: we are involved in the lives of all our members. Through pastoral visits we are always checking on people, through hospital visits we make sure friends and fellow believers who are sick never feel lonely because we are there accompanying them on the journey. In the Gospel of Luke, the text above is a text that we should reflect on always but especially as we are planning on being prepared for disasters.

- ü Faith communities are implored to "dress for action" – this is an interesting exhortation. We live in a world in which dressing for action is a common occurrence, athletes dress for action, soldiers dress for action, faith leaders, priests, and pastors' dress for action too. Dressing for action means be prepared, be ready to act when called upon. Disasters require us to always be dressed for action, when it strikes, we may not have time to start dressing for action, we ought to be dressed already.

- ü The listeners of Jesus were implored to have their lamps lit! Having a lamp is not enough, having it lit is what really matters. There are people who have scars from bumping into walls because electricity went off and left them in utter darkness. They had lamps, everyone has a lamp in their house, but when electricity was switched off, some had not lit their lamps. We ought to have our lamps lit before disaster strikes.

- ü Then a servant or slave metaphor is also used. Servants whose master is out will not sleep before the master returns; they will stay awake in readiness to open the doors as soon as the master arrives. There will not be time to wake up and dress before opening the doors because the master is an impatient person. Disasters are like the impatient master, we will not normally get time to go and be prepared before it strikes, we must always be expecting and ready.

- ü What is clear from this text is that we must always be ready to take action, action to spread the good news, action to spread the love, action to spread the true knowledge of God. We must also, from today, be ready to assist our communities deal with the impact and effects of disasters whenever disasters strike our communities. We must even begin by helping our communities prepare and ready themselves in case a disaster were to strike our community. Just as we prepare people for heaven, let us also prepare them for disasters!

Our God, loving and caring, covering us in Grace is always prepared to come to our rescue! Being prepared to rescue ourselves and others is our way of imitating our ever ready and prepared God. Preparedness is divinely ordained.

Discussion Question

What biblical texts help you understand the concept of disaster preparedness?

UNIT ELEVEN:
HEALTH PROMOTING CHURCHES AND PREPAREDNESS

Unit Description

This course is a continuation of the previous course on Disaster and Risk Management for Religious leaders. This second part of the course explores how the church can be a place of new infections in the time of an outbreak. Further, the course also explores how the church can/should be prepared for events of outbreaks and others. The course helps to illustrate how church preparedness is key to a healthy Church and community. (Examples of COVID-19 as an emergency that has awakened many why health and preparedness matters. The lecture can also include other pandemics that have been ignored like SGBV and Mental health issues & transgenerational trauma hence the church should always be alert).

Unit Purpose

The purpose of this course is to introduce the students to the knowledge of church preparedness and to anticipate disasters that are likely to affect them, further, to think of ways to reduce the impact, or prevent disasters altogether. This course seeks to equip students with the necessary information on Church Preparedness.

Unit Objectives

a) Upon completion of this unit, you should be able to:
b) Define Church Preparedness
c) Discuss the dimensions of Church Preparedness
d) Describe the Church Preparedness Model
e) Discuss when to use the Church Preparedness model

Unit Outline

Day One: Preventing the Spread of Infection in Churches

Public health has as its mission and privilege the promotion of physical and mental health in populations as well as the prevention of disease, injury, and disability. With the community as its client, public health is successful in forging partnerships which aid in the early identification of health risks and the minimization of their impact on populations. The Church has been suggested as one such public health partner. As a respected facet of community life, churches provide support and resources in times of crisis which are familiar and dependable. In a normal influenza season, hundreds of people become ill. Many require hospitalization and some die. Should a severe new strain of influenza appear, this number would increase dramatically. The unpredictability of viruses, place people at risk throughout the year not just during the "cold and

flu" season. Preparing for pandemics and their effect on communities has occupied considerable time and planning dollars among public health professionals and the population in general. Public health is encouraging churches to adopt a policy to alter or eliminate common practices known to spread disease.

Common Practices Which Spread Disease

There are some common practices that promote the spread of disease. These include but are not limited to: greeting members and visitors before and after services with a handshake; passing the peace using a handshake; communion services where a common cup or loaf are used or where a wafer is placed on the tongue of each recipient from a single server; Sunday school rooms and toys; coffee hours and other social events, as well as visitations to nursing homes, hospitals, retirement homes and private residences. Germs on the hands of individuals who cough, sneeze, wipe their mouths or even cover a yawn are easily passed on to others through a handshake or the touching of a common object or use of a common cup. Any person may harbour microorganisms that are currently harmless to them but potentially harmful to another person. Depending on the infectiousness of the germs being passed, hands or common items may remain infected for a long period of time. Handshaking and the sharing of common objects in worship services, while symbols of hospitality and spiritual bonding, are also efficient avenues for disease transmission. Frequent handwashing and the avoidance of using common objects have proven to be effective infection control measures.

Recommendations

To help control the spread of illness in congregations, please consider some of the following strategies:

- Urge parishioners who are ill to refrain from attending services.
- Encourage members with cough/sneeze illness to avoid activities, during the service, where they come into direct contact with other members or common items.
- Make an announcement during the service, and in the bulletin, asking members to forego the handshake of fellowship to help prevent the unintentional spread of disease.
- Substitute another activity for handshaking when greeting each other before and after services and when "sharing the peace." Nodding the head, touching the shoulder or waving the hand are a few suggestions.
- If unsuccessful in substituting an activity for handshaking, consider eliminating the portion of the service where "sharing the peace" or other handshaking occurs.
- Ask parishioners to extend hands in front of themselves, palms up, for special prayers where hands are usually held.
- Use individual cups for communion wine or grape juice.
- Have communion servers clean hands with sanitizer before distribution of the elements,

then, place the communion bread or wafer into the palm of the recipient without touching his or her hand

- Have tissues and hand sanitizer gel available in each pew.
- Be sure classrooms and meeting rooms are stocked with Kleenex and hand sanitizer.
- Clean toys in nurseries and classrooms after each use.
- Encourage handwashing, using hot, soapy water as often as possible, particularly before handling food and after using restrooms.

Conclusion

Healthy congregations in healthy communities are the goal of public health and its partners. The Church is an integral part of the infection-control process. Eliminating the shaking of hands and the use of common objects before, during and after worship services, can have a significant impact on the achievement of this goal and the potential containment of serious threats to health.

Discussion Question

Do you think it's necessary to re-think our theology of worship in light of COVID-19 and other pandemics?

Day Two: Preparedness

Yesterday we learnt about how to prevent the spread of infectious diseases within the church and the community. This lesson showed us how vulnerable the church is to infections, but it also gives an opportunity for the church to prepare for infection pandemics and other disasters that are likely to take place. Today, we want to look at Church preparedness.

What is Church Preparedness?

Church Preparedness: Identifies the steps required to prepare for an outbreak, including gap analysis and capacity building activities (i.e., training, pre-agreement on standards, messages, etc.), pre-positioning of supplies, adapting and pre-positioning of IEC materials, identification of partners and pre-defined agreements for response implementation, among others. It also includes information on response in the event of an outbreak (a response plan), needs and required resources to address these needs.

Church preparedness is the degree to which a Church is ready to act on an issue.

That preparedness can range from none at all (e.g., the community has never even heard of the issue in question – think of AIDS in 1982) to already having successful programs in place and making headway. Church Preparedness has some specific characteristics that are important for

community builders to understand:

- *Church preparedness or readiness is issue-specific.* A Church can be more than ready to address one issue, while being at the very earliest stages of readiness in relation to another. It is measurable. It is measurable across multiple dimensions. Not only can one get an accurate assessment of community readiness, one can accurately measure where the community is on various elements of readiness.
- *Church preparedness/readiness can vary across dimensions.* A Church may be more ready to address an issue in some ways than in others. It may know a great deal about the issue and realize it is a problem, for instance, but be unable to conceive of implementing a particular solution.
- *Church preparedness/readiness can vary across different segments of the community.* Some groups – those directly affected by the issue, for example – may be far more ready to deal with it than others. However, as we will see, there are some ways to help move communities toward higher levels of readiness.
- *Understanding church preparedness/ readiness is essential knowledge for addressing an issue.* One can easily doom an effort by trying to push a community into something it is not ready for. People will only support what they see as reasonable, logical, and doable. One may be proposing something that is all of those, but if the community's perception is otherwise, the effort is unlikely to be successful.

An understanding of church preparedness allows one to tailor an intervention or strategy to what the community is willing to accept and support. By taking small steps forward – by setting goals that necessitate a stretch for people, but not so great a stretch as to be beyond their current ability and understanding of the issue – one can make steady progress.

Discussion Question
What is Church preparedness and what are some specific characteristics that are important for community builders to understand in Church preparedness?

Day Three: Church preparedness

Yesterday we learnt about church preparedness and *some specific characteristics that are important for community builders to understand in Church preparedness*. Today, we want to look at the dimensions of church preparedness, the key factors that influence the Church preparedness.

DIMENSIONS of Church preparedness

Dimensions of preparedness are key factors that influence the Church's preparedness to take

action on an issue. Six dimensions identified are:

1) **Church efforts**. To what extent are there existing efforts, programs, and policies that address the issue?
2) **Church knowledge of the efforts**. To what extent do Church members know about existing local efforts and their effectiveness? Are the efforts accessible to all members of the church?
3) **Leadership**. To what extent are leaders and influential community members supportive of the issue?
4) **Church Climate**. What is the prevailing attitude of the Church toward the issue? Is it one of helplessness or one of responsibility and empowerment?
5) **Church knowledge about the issue**. To what extent do Church members know about the causes of the problem, consequences, and how it impacts your Church and Community?
6) **Resources related to the issue**. To what extent are local resources – people, time, money, space, etc. – available to support efforts?

The Church's status with respect to each of the dimensions forms the basis of the overall level of Church preparedness. Remember that readiness can vary sometimes widely across dimensions, so that, for example, levels of Church efforts and resources may be very different. The levels of preparedness describe just how prepared your Church is to tackle the issue in question. The Church's level for the issue you are concerned about doesn't necessarily correspond to its level on other issues (remember that Church preparedness is issue-specific).

Discussion Question
Identify the six dimensions of the Church preparedness model

Day Four: Church Preparedness Model

Yesterday, we looked at the dimensions of church preparedness, the key factors that influence the Church preparedness. It was worth noting that church readiness can vary sometimes widely across dimensions, so that, for example, levels of Church efforts and resources may be very different. The levels of preparedness describe just how prepared your Church is to tackle the issue in question. Today we will try to answer the question of why the use of the church preparedness model, or why the church should be prepared.

WHY USE THE CHURCH Preparedness MODEL?

- ✓ **It conserves valuable resources (time, money, people) by guiding the selection of strategies that are most likely to be successful**. Rather than spinning your wheels trying

to get the community to do something it is not ready for, you and the community can get up to speed quickly by starting in the right place.

- ✓ **It is an efficient, inexpensive, and easy-to-use tool**. It does not take professional expertise to administer or score, it is free, and it works.
- ✓ **It promotes community recognition and ownership of the issue.** Because it can be used by church members who are community members, and because it recognizes the needs and assumptions of the community, the model makes it easier for community members to see the issue and understand its effects.
- ✓ **Because of strong community ownership, it helps to assure that strategies are culturally congruent and sustainable**.
- ✓ **It encourages the use of local experts and resources instead of reliance on outside experts and resources**. Those local experts may not be "experts" in the professional sense, but rather community members who understand what's going on and know the community.
- ✓ **The process of community change can be complex and challenging, but the model breaks down the process into a series of manageable steps**. Moving from no readiness to the highest level is a long step. Moving from the lowest level to the next one up is manageable and easy to understand.
- ✓ **It creates a community vision for healthy change**. The levels of readiness mirror the levels of community competency, and describe, to some extent, how a healthy community handles issues.

Discussion Question
Why is the use of Church preparedness model important to use in the time of disasters or pandemics?

Day Five: Using the Church Preparedness Model

Yesterday, we asked the question of why the Church preparedness model and so today, we shall look at when the church preparedness should be used.

When should you use the Church Preparedness Model?

The nature of the model makes it useful in virtually any situation where an issue needs to be addressed, but there are sometimes when it can be particularly useful.

- ✓ **In the course of an ongoing effort.** If your effort is successful, the community will be moving forward, not only in dealing with the issue, but in readiness. In order to make sure that it continues to work on tasks and goals that most members can accept and accomplish – and to move forward – it is important to monitor readiness and adjust your strategy accordingly.

- ✓ **Each time you tackle a new issue**. Because church preparedness is issue-specific, it's important to know where the community falls on each issue you address. Successful work on one issue may leave the community better prepared and more willing to address others, or it may leave community members complacent, and feeling that there is not much more to be done. In either case, a campaign will have to respond to where the community is currently.
- ✓ **When several different communities, or different segments of the community, are involved.** As we have discussed, groups within the community may be in very different places on the readiness scale. You may need a unique strategy for each in order to mount a successful effort.
- ✓ **When you are planning an effort that involves a participatory process**. What level of participation can you expect to begin with? Where do you have to start in order to have a reasonable possibility of success? Applying the model will help to answer these and similar questions.
- ✓ **When you are engaged in a community or neighbourhood planning effort**. Many such efforts start with the assumption that everyone is at the same readiness level, but provide very little encouragement to move. A close look at where the community or neighbourhood is actually starting from might both speed up the process and broaden involvement and subsequent satisfaction with the results.

Discussion Question

Describe the five occasions in which the Church preparedness model can be used.